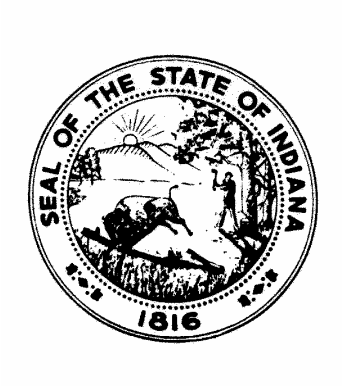


State of Indiana
Family and Social Services Administration

Request for Proposals 7-54

(RFP 7-54)

For a contractor to take over operation of the
the Medicaid Management Information System (MMIS)
(Indiana Advanced Information Management System (AIM))
and provide Fiscal Agent services

Issued by the
Office of Medicaid Policy and Planning (OMPP)

Contact: Jessica Robertson, Senior Account Manager
Indiana Department of Administration
Procurement Division
402 W. Washington St., Room W468
Indianapolis, Indiana 46204

Table of Contents

ATTACHMENTS:

Attachment A:	Minority & Women's Business Enterprise RFP Subcontractor Commitment Form
Attachment B:	Sample Contract
Attachment C:	Indiana Economic Impact Form

1 General Information

1.1 Introduction

In accordance with Indiana statute, including IC 5-22-9, the Indiana Department of Administration (IDOA), acting on behalf of the Family and Social Services Administration (FSSA), procures Fiscal Agent and Medicaid Management Information System programming and operation services for the FSSA Office of Medicaid Policy and Planning (OMPP).

It is the intent of IDOA to solicit responses to this Request for Proposals (RFP) in accordance with the statement of work, proposal preparation section, and specifications contained in this document.

This RFP is being posted to the IDOA website (http://www.IN.gov/idoa/proc) for downloading. A nominal fee will be charged for providing hard copies.

Neither this RFP nor any response (proposal) submitted hereto are to be construed as a legal offer.

1.2 Definitions and Abbreviations

The explanations of terms and abbreviations appearing throughout this RFP are defined in Appendix A – Glossary of Terms.

1.3 Purpose of the RFP

The purpose of this RFP is to select a Contractor that can satisfy the State's need for takeover and operation of the Indiana MMIS and provision of Fiscal Agent services as defined in Section 5, Scope of Work. It is the intent of FSSA OMPP to contract with a Respondent that provides quality MMIS operation and Fiscal Agent services for FSSA OMPP.

1.4 RFP Issued Subject to CMS Approval

This Request for Proposals (RFP) is issued prior to its review by the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). CMS will review the RFP and may require the State to make changes in the RFP, procurement schedule, evaluation process, or resulting contract language. Any changes agreed upon between the State and CMS will be made by the State issuing an amendment or amendments to the RFP and by notification to known potential Respondents.

Respondents prepare proposals at their own risk. The State will not be liable for any part of the cost of preparing the proposals or making modification to the proposals, even if such a modification is required based on an amendment to the RFP.

Any contract or contracts resulting from this RFP are also subject to CMS approval.

1.5 Summary Scope of Work

The State intends to finalize a contract with the Respondent that submits a proposal in response to this RFP evaluated at the sole discretion of the State to be in the best interest of the State. The State will consider price, performance history, financial information, economic impact, use of minority-owned and woman-owned services, and other factors at the State's discretion in making the evaluation.

The largest single component of the evaluation, however, will be of the Respondent's ability to perform the scope of work and honor all of the contractual requirements specified in this RFP. The contractual requirements are identified in detail in section 4 of this RFP. The scope of work is identified in detail in section 5 of this RFP. The full scope of work encompasses every requirement contained in the RFP, including all chapters, RFP attachments, appendices, and documents specifically referenced as requirements in any part of the RFP.

Respondents are encouraged to submit questions about any requirements they consider unclear, using the process described in section 2.2. Interpretation of the requirements after contract award is at the sole discretion of the State.

The following is a summary of the services to be performed. The items described in this summary section are not comprehensive, but are intended to give the Respondent a broad overview of the scope of this RFP.

1.5.1 Fiscal Agent Services and MMIS Operation

The Contractor will receive all computer files, programs, documentation, instructions, equipment, paper files, manuals, post office boxes, telephone numbers, Internet addresses and other materials, tangible and intangible owned by the State and currently in the possession of the incumbent fiscal agent for the operation of the State's Medicaid program. This includes the Medicaid Management Information System (MMIS) developed, modified and operated by the incumbent to record recipient eligibility, enroll service providers and maintain provider records, receive and process Medicaid and ancillary claims, and perform all services for which the MMIS was designed.

The Contractor will operate the MMIS and serve as the State's Medicaid Fiscal Agent for a period of at least five years, subject to the terms of the Contract. As Fiscal Agent, the Contractor will use the MMIS and other technological and manual processes to do all of the State's business in the operation of the Medicaid program, under the supervision and at the direction and limitation of the State.

1.5.2 MMIS Maintenance and Modifications

The Contractor will maintain and modify the MMIS at the direction of the State, and assure uninterrupted operation and continued certification of the MMIS as meeting federal requirements to qualify for maximum Federal Financial Participation. The Contractor will maintain adequate staff, both in numbers and in qualifications to meet this requirement.

1.5.3 Indiana Health Coverage Programs (IHCP) Responsibilities

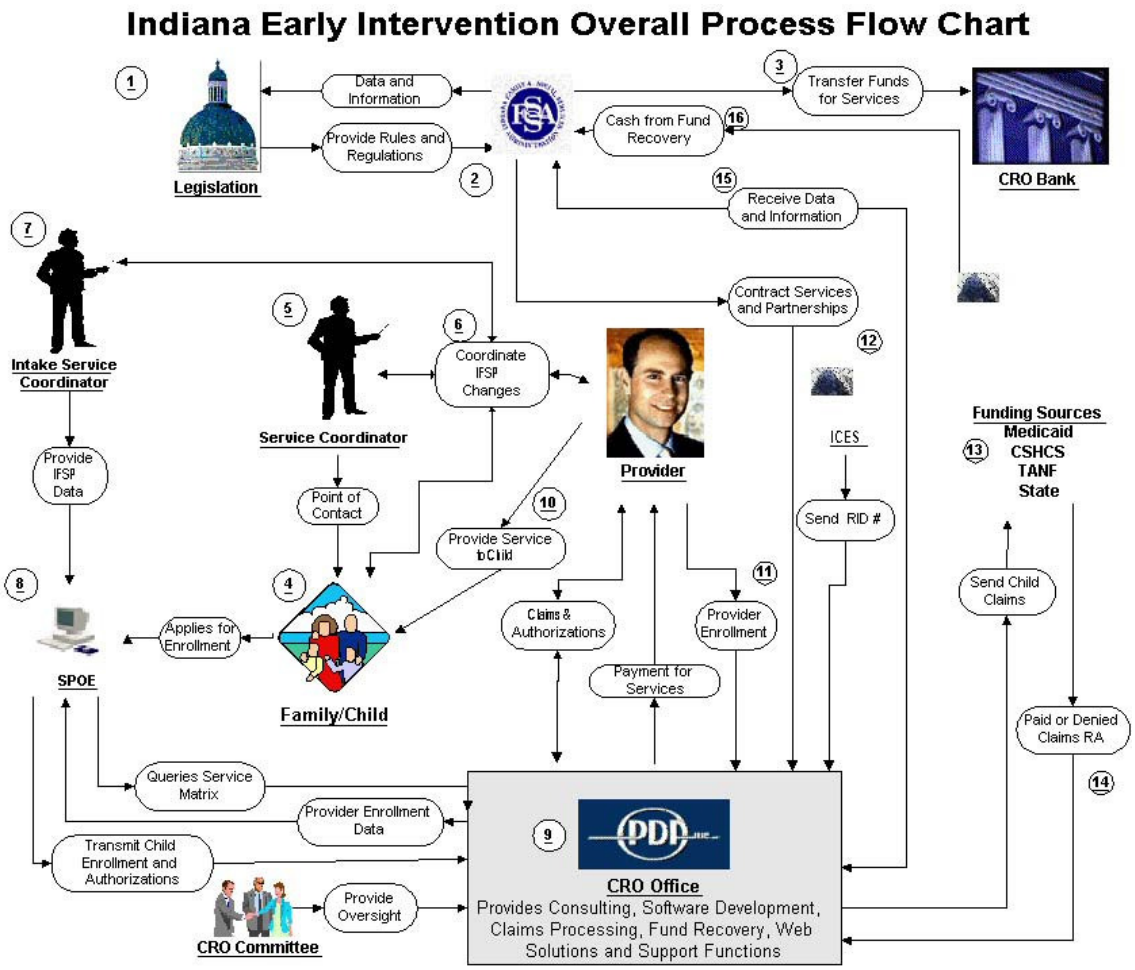
In addition to Medicaid, the Contractor is responsible to provide and account for services to medical assistance programs offered by Indiana under the umbrella of Indiana Health Coverage Programs (IHCP), including but not limited to the State Children's Health Insurance Program (SCHIP), Hoosier Healthwise, the 590 program, First Steps (an early intervention program) and Aid to Residents in County Homes (ARCH). Services specific to First Steps, Medicaid and SCHIP recipients are provided through a variety of delivery systems, a Primary Care Case Management (PCCM) program, Risk-Based Managed Care (RBMC) arrangements, services contracted through enrollment brokers, managed care organizations (MCOs), fee-for-service (FFS) providers, and others.

Other IHCP functions include responsibilities related to the Medical Review Team (MRT), that determines disability specific to Medicaid eligibility, and that conducts the Pre-Admission Screening and Resident Review (PASRR) for nursing home candidates.

1.5.4 Indiana First Steps Early Intervention Program

Each Respondent must separately price the performance of services, programming and operation of services to manage the Indiana First Steps Early Intervention Program.

The following flow charts demonstrate the highlights of the process for the Indiana First Steps program, including claims processing:



Early Intervention Overall Process Flow

1. **Legislation**
- Provides Rules and Regulations to State

2. **Family/Child**
- Applies for Enrollment at one of the county System Points of Entry (SPOE)

3. **Service Coordinator**
- Point of Contact for Family/Child
- Supplies data for the county SPOE
- Coordinates IFSP Change

4. **Provider**
- Clinician who provides services to the client

5. Intake Service Coordinator

- Provides IFSP Data to SPOE
- Participates in the coordination of services needed for the Child

6. System Point of Entry (SPOE)

- Receives Provider Enrollment data from CCG/the respondent contractor via the internet
- Sends Service Authorizations to CCG/the respondent contractor via the internet
- Uses the Service Matrix to obtain the most current information concerning Providers including their availability to perform services.
- Sends Child enrollment to CCG/the respondent contractor via the internet.

7. Central Reimbursement Office (CRO)

- Provides Provider Enrollment Data to the SPOE via the internet
- Performs Fund Recovery operations
- Warehouses all data in the First Steps program
- Processes Claims received from Providers in paper and electronic format
- Sends Authorizations for Service to Providers
- Maintains quality of enrolled Providers using standards established by the State
- Enrolls new Providers
- Sends data for reporting, auditing and further Fund Recovery procedures
- Maintains financial information
- Supports the SPOE offices
- Provides defined support for the Provider

8. Provider

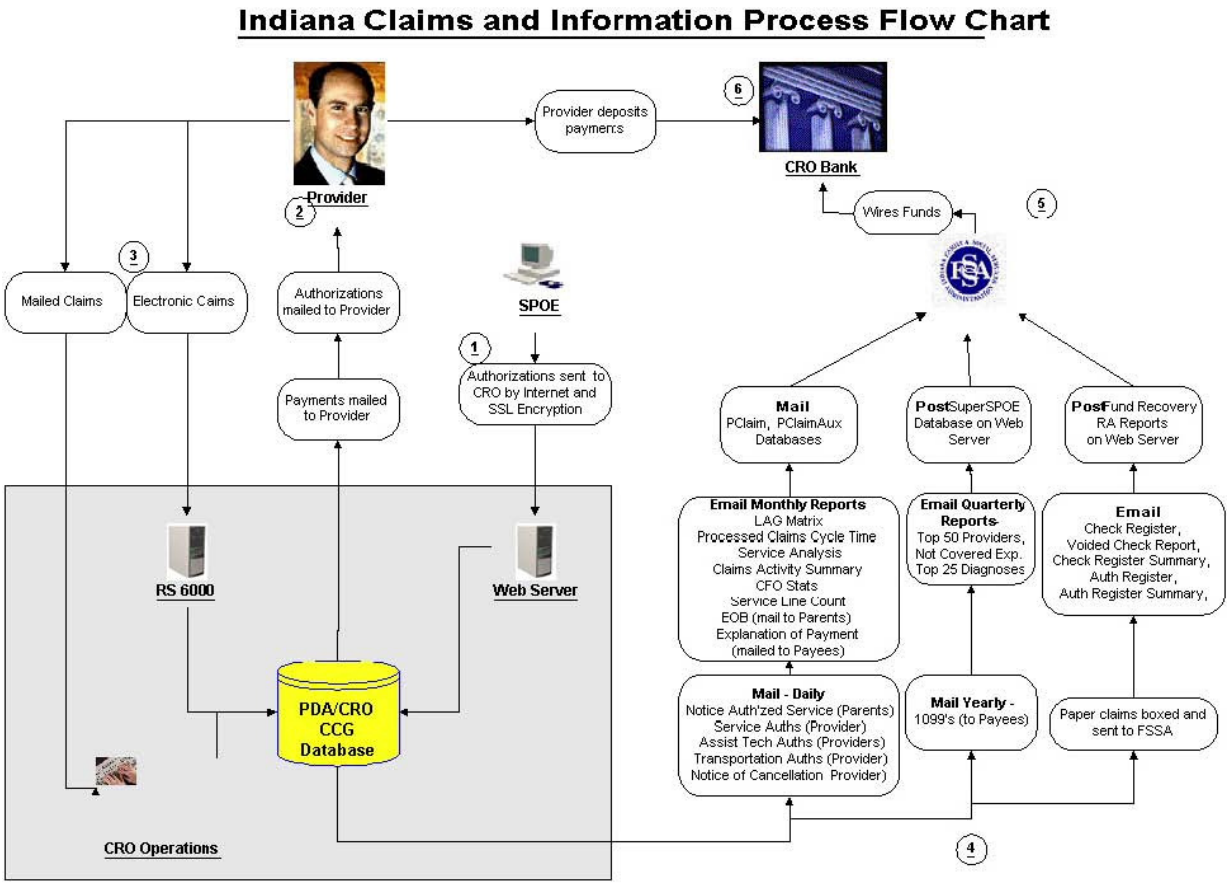
- Provides Service to Child/Client
- Provider Enrolls with the CRO
- Mails or electronically sends Claims to CRO
- Receives payment from CRO on funds drawn on the CRO bank
- Receives Service Authorizations from the CRO
- Credentials/recredentials with the CRO

9. State

- Receives Authorization information from the CRO
- Receives information to complete parts of Fund Recovery
- Receives summarized Claim information from the CRO
- Receives funds from Fund Recovery
- Completes required Federal and State reporting
- Transfers funds to the CRO bank
- Audits the CRO where appropriate or necessary
- Maintains credential/recredential standards for Providers
- Determines rates of reimbursement of Provider claims
- Performs State administrative functions of the CRO
- Determines and prioritizes future development work
- Funding Sources – Medicaid, CSHCS, TANF and State
- Transfers Funds for Services to Central Reimbursement Office (CRO) bank
- CRO Bank issues checks drawn on those funds
- Receives funds based on claims submitted by providers using information received from the respondent Contractor

10. Medicaid

- Pays or Denies Claims
- Sends Remittance Advice (R.A.s) to CRO Office
- Deposits paid Claims amount at the State


Indiana Claims and Information Process Flow Chart
Provider
Provider deposits payments
6
CRO Bank
Wires Funds
5
2
3
Mailed Claims
Electronic Caims
Authorizations mailed to Provider
SPOE
1
Authorizations sent to CRO by Internet and SSL Encryption
Payments mailed to Provider
Mail
PClaim, PClaimAux Databases
PostSuperSPOE Database on Web Server
PostFund Recovery RA Reports on Web Server
Email Monthly Reports
LAG Matrix
Processed Claims Cycle Time
Service Analysis
Claims Activity Summary
CFO Stats
Service Line Count
EOB (mail to Parents)
Explanation of Payment (mailed to Payees)
Email Quarterly Reports
Top 50 Providers,
Not Covered Exp.
Top 25 Diagnoses
Email
Check Register,
Voided Check Report,
Check Register Summary,
Auth Register,
Auth Register Summary,
RS 6000
Web Server
PDA/CRO CCG Database
Mail - Daily
Notice Auth'zed Service (Parents)
Service Auths (Provider)
Assist Tech Auths (Providers)
Transportation Auths (Provider)
Notice of Cancellation Provider)
Mail Yearly -
1099's (to Payees)
Paper claims boxed and sent to FSSA
CRO Operations
4

Claims and Information Process Flow

1. **SPOE**

- Authorizations sent to CRO by the SPOEs using the internet and SSL Encryption
- Web Server receives the files from the SPOEs and imports them into the CRO
- SPOEs are notified of errors in the transmitted data via messages that are returned. These must be corrected and resent or it may result in authorizations and / or claims not being processed.

2. **CRO CCG Database**

- Payments mailed to Provider
- Authorizations Mailed to Provider

3. **Provider**

- Submits Electronic Claims

4. **CCG Database**

- Generates the following daily reports:
  - Notice of Authorized Service
  - Service Authorizations
  - Assistive Technology Authorizations
  - Transportation Authorizations
  - Notice of Cancellation
  - Authorization Register and Authorization Register Summary

- Generates the following monthly reports:
  - LAG Matrix
  - Processed Claims Cycle Time
  - Service Analysis
  - Claims Activity Summary
  - CRO Statistics
  - Service Line Count
  - Explanation of Benefits (EOB)
  - Provider Enrolled Credential Report

- Generates the following reports twice per week:
  - Check
  - Explanation of Payment
  - Printed Check Report
  - Voided Check Report
  - Register of Paid Claims

- Generates the following reports Quarterly:
  - Top 50 Providers

- Not Covered Expenses
- Top 25 Diagnoses

- Generates the following reports yearly:
  - 1099's
  - Generates Extract Files
  - Generate and post Pclaim, PclaimAux Databases to the State for Claims data
  - Posts R.A. Reports on the Web Server for the State's usage
  - Generates SuperSPOE for Provider and Authorization data for the State.
  - SuperSPOE is posted on the Web Server.

5. FSSA

- Transfers cash to the CRO bank
- Uses data supplied from CRO to generate reports and to audit system

1.5.5 General Operating Statistics and Key Activities

Indiana Medicaid now serves more than one million recipients, maintains records on more than 38,000 service providers, and processes more than 31 million fee-for-service claims per year.

The Fiscal Agent performs the following services or provides significant support to other contractors that provide these services:

- Actuarial Analysis
- Medical Policy and Surveillance Utilization Review
- Managed Care Organization Monitoring, including receipt and processing of encounter data
- Enrollment Brokering
- Decision Support System and Data Analysis
- Auditing
- Rate Setting
- Cost Settlement
- Pharmacy Benefits Management
- Disease Management
- Provider Enrollment
- Provider Training
- Third Party Liability Activities

1.5.6 MMIS Systems History and Current Operations

The Respondent selected for a contract resulting from this procurement must provide a level of service in all areas, including First Steps, if the State includes those services in the contract resulting from this RFP that meets or exceeds the level of service provided by the incumbent

contractor, except as specifically identified in writing by the State. Although the State has attempted to capture all requirements accurately, the State and the Respondent acknowledge the possibility of ambiguity, lack of detail, or misunderstanding of requirements.

Therefore, it is critical for the Respondent to study system documentation and other materials in the procurement library before submitting a bid. The State is the final arbiter regarding the meaning, intention and requirements of the RFP, and by submitting a response to this RFP, Respondent assumes all risks associated with the possibility that they may have underestimated the requirements, or failed to understand the specific requirements of the State or the current level of service that must be met.

The following history and description of current operations is provided to facilitate a general understanding of the scope of the MMIS and fiscal agent requirements.

Indiana Advanced Information Management System (AIM) is the Indiana MMIS. IndianaAIM was installed in the early 1990s by Electronic Data Systems (EDS). The State owns the MMIS software. The system runs on Sun/Unix computers in a multi-tiered environment that includes several dozen servers, mirrored disk arrays, Oracle databases, numerous large batch programs compiled from the c and Cobol programming language, Powerbuilder, Microsoft .asp and Microsoft .NET presentation panels and reports, and Sybase transaction translation.

Integrated components handle imaging, document storage and management, letter and form generation, report archiving and access, and Medicaid identification card production. The contract includes operation of a major telephone call center with Computer/Telephone integration (CTI) and a high-volume Automated Voice Response System (AVRS).

Electronic transactions are received through a high-capacity Electronic Data Interchange (EDI) unit that handles tapes, disks in various formats, FTP, secure FTP, file exchange protocols, TCP/IP, and other interfaces. The contract includes programming for and operation of web portals that provide static, dynamic and interactive services. All HIPAA-mandated electronic transactions are handled with servers, translator, pre-processor and appropriate network routing architecture.

Contract requirements include operation of a mailroom that receives large volumes of mail daily, including an average of more than 12,000 paper claims per day. All paper claims and many other documents are imaged for access through IndianaAIM. Claim data is entered from images and paper documents using Captiva software. The contract requires production and distribution of manuals, forms and information letters in print and by compact disk.

To meet infrastructure and data interchange requirements of the contract, the contractor maintains communications circuits, routers, servers and

networks to handle interfaces and internal and external communications. The contractor is required to provide technical assistance and equipment for state Medicaid staff.

The contract also requires operation of a separate DSS with Oracle databases accessed through Business Objects and analytical tools.

The current system provides interfaces between AIM and other electronic data processing systems, and generates reports and recipient explanation of Medicaid benefits. The fiscal agent performs data entry services and completes requirements to support the federal certification process.

1.6 RFP Outline

The outline of this RFP document is described below:

Section	Description
Section 1 – General Information and Requested Products or Services	This section provides an overview of the RFP, general timelines for the process, and a summary of the products/services being solicited by the State/Agency via this RFP
Section 2 – Procurement Schedule	This section presents the timeline for the procurement and implementation process.
Section 3 – Proposal Preparation Instruction	This section provides instructions on the format and content of the RFP including a Letter of Transmittal, Business Proposal, Technical Proposal, and a Cost Proposal
Section 4 – Contractual Requirements	This section presents general contractual terms that will become part of the contract resulting from this RFP.
Section 5 – Scope of Work	This section describes in detail the requirements for takeover operation of the MMIS and performance of the services required of the Fiscal Agent.
Section 6 – Proposal Evaluation Criteria	This sections discusses the evaluation criteria to be used to evaluate respodents' proposals
Section 7 – Contract Attachments	Attachment A: MWBE Participation Plan Form Attachment B: Sample Contract Attachment C: Indiana Economic Impact Form
Section 8 – Reference materials	This section presents materials that should be considered by the responders, including technical descriptions and statistics related to current MMIS and Fiscal Agent operations.

2 Procurement Schedule

2.1 Summary of Milestones

The following timeline is only an illustration of the RFP process. The dates associated with each step are not to be considered binding. Due to the unpredictable nature of the evaluation period, these dates are commonly subject to change. At the conclusion of the evaluation process, all Respondents will be informed of the evaluation team's findings.

Activity	Date
The dates for the following activities are target dates only. These activities may be completed earlier or later than the date shown.	
Issue of RFP	December 1, 2006
Deadline to Submit Written Questions	December 22, 2006
Pre-Proposal Conference	December 6, 2006
Response to Written Questions/RFP Amendments	January 5, 2007
Submission of Proposals	January 15, 2007
Proposal Evaluation	February 26, 2007
Proposal Discussions/Clarifications (if necessary)	February 16, 2007
Oral Presentations (if necessary)	February 16, 2007
Best and Final Offers (if necessary)	February 23, 2007
Contract Award	March 1, 2007

2.2 Question/Inquiry Process

All questions/inquiries regarding this RFP must be submitted in writing by the deadline of **3 p.m. Eastern Time** on December 22, 2006. Questions/Inquiries may be submitted via e-mail rfp@idoa.IN.gov and must be received by Procurement Division by the time and date indicated above.

Following the question/inquiry due date, Procurement Division personnel will compile a list of the questions/inquiries submitted by all Respondents. The responses will be posted to the IDOA website according to the RFP timetable established in Section 2.1. The question/inquiry and answer link will become active after responses to all questions have been compiled. Only answers posted on the IDOA website will be considered official and

valid by the State. No Respondent shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee.

Inquiries are not to be directed to any staff member of FSSA. Such action may disqualify Respondent from further consideration for a contract resulting from this RFP.

If it becomes necessary to revise any part of this RFP, or if additional information is necessary for a clearer interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be posted on the IDOA website. If such addenda issuance is necessary, the Procurement Division may extend the due date and time of proposals to accommodate such additional information requirements, if required.

2.3 Due Date for Proposals

All proposals must be received at the address below by the Procurement Division no later than **3 p.m. Eastern Time** on January 15, 2007. Each Respondent must submit one original (marked "Original") and eight (8) complete copies of the proposal, including the Transmittal Letter and other related documentation as required in this RFP. A complete copy of the proposal must be provided on CD-ROM. Each copy of the proposal must follow the format indicated in Section 3 of this document. Unnecessarily elaborate brochures or other presentations, beyond those necessary to present a complete and effective proposal, are not desired. All proposals must be addressed to:

Indiana Department of Administration
Procurement Division
402 West Washington Street, Room W478
Indianapolis, IN 46204

Caution to Respondents about shipping/mailing: United States Postal Express and Certified Mail are both delivered to the Government Center Central Mailroom, and not directly to the Procurement Division. It is the responsibility of the Respondent to make sure that solicitation responses are received by the Procurement Division at the Department of Administration's reception desk on or before the designated time and date. Late submissions will not be accepted. The Department of Administration, Procurement Division clock is the official time for all solicitation submissions.

All proposal packages must be clearly marked with the RFP number, due date, and time due. Any proposal received by the Department of Administration, Procurement Division after the due date and time will not be considered. Any late proposals will be returned, unopened, to the Respondent upon request. All rejected proposals not claimed within 30 days of the proposal due date will be destroyed.

No more than one proposal per Respondent may be submitted.

The State accepts no obligations for costs incurred by Respondents in anticipation of being awarded a contract.

All proposals submitted to the State should be double-sided and printed on 30% post-consumer recycled content paper or tree-free paper. When possible, soy ink should be used. The Respondent should indicate compliance with this paragraph in the Transmittal Letter described in Section 3.2.

2.4 Pre-Proposal Conference

FSSA will host a pre-proposal conference on December 6, 2006 at the FSSA, 402 West Washington Street, Indianapolis, Indiana, 46207 – Indiana Government Center Auditorium. The purpose of this conference will be to explain the procurement process and scope of work covered by this RFP. At this conference, potential respondents may ask questions about the RFP and the RFP process. Respondents are reminded that no answers issued verbally at the conference are binding on the State and any information provided at the conference, unless it is later issued in writing, is not binding on the State. To receive official answers, all questions must be submitted according to the provisions of Section 2.2 Question/Inquiry Process.

2.5 Modification or Withdrawal of Offers

Modifications to this RFP may only be made in the manner and format described in amendments to the RFP that may be issued under the procedures described in Section 2.2. Amendments supersede this document, and may alter requirements, deadlines, formats, procedures, meetings, evaluation criteria, or any other facet of this procurement.

The Respondent's authorized representative may withdraw the proposal, in person, prior to the due date. Proper documentation and identification will be required before the Procurement Division will release the withdrawn proposal. The authorized representative will be required to sign a receipt for the withdrawn proposal.

Modification to, or withdrawal of, a proposal received by the Procurement Division after the exact hour and date specified for receipt of proposals will not be considered.

2.6 Pricing

Pricing on this RFP must be firm and remain open for a period of not less than 180 days from the proposal due date.

Please refer to Section 3.5 for a detailed discussion of the proposal pricing format and requirements.

2.7 Proposal Clarifications and Discussions, Contract Discussions

The State reserves the right to request clarifications on proposals submitted to the State. The State also reserves the right to conduct proposal discussions, either oral or written, with Respondents. These discussions could include request for additional information, request for cost or technical proposal revision, etc. Additionally, in conducting discussions, the State may use information derived from proposals submitted by competing Respondents only if the identity of the Respondent providing the information is not disclosed to others. The State will provide equivalent information to all Respondents which have been chosen for discussions. Discussions, along with negotiations with responsible Respondents may be conducted for any appropriate purpose.

The Procurement Division will schedule all discussions. Any information gathered through oral discussions must be confirmed in writing.

A sample contract is provided in Attachment B. Any requested changes to the sample contract must be submitted with your response. (See Section 3.3.5 for details.) It is the State's expectation that any material elements of the contract will be substantially finalized prior to contract award.

2.8 Best and Final Offer

The State may request best and final offers from those Respondents determined by the State to be reasonably viable for contract award. However, the State reserves the right to award a contract on the basis of initial proposals received. Therefore, each proposal should contain the Respondent's best terms from a price and technical standpoint.

Following evaluation of the best and final offers, the State may select for final contract negotiations/execution the offers that are most advantageous to the State, considering cost and the evaluation criteria in this RFP.

2.9 Reference Site Visits

The State reserves the right to request a site visit to a place or places where one or more Respondents provide similar service to those being requested under this RFP. Such request will be made at the sole discretion of the State. If and when the State exercises this option, all Respondents submitting bids will be notified as appropriate.

3 Proposal Preparation Instruction

3.1 General

To facilitate the timely evaluation of proposals, a standard format for proposal submission has been developed and is described in this section. All Respondents are required to conform to the following requirements

and proposals must be prepared according to the instructions in this section.

The table is provided to assist the Respondent in preparing their proposal. However, the table does not contain all required information and the Respondent is to meet the requirements of each section as stated in the specific section (and is not to rely on the table for completion of content).

A Respondent shall submit one (1) original and eight (8) copies of its Transmittal Letter, Business Proposal, Technical Proposal, Cost Proposal and Forms in a sealed package.

Each item must be addressed in the Respondent's proposal. Succinct responses are preferred.

Section	TAB	Proposal Reference	Description
1	**1**	**3.2**	**Transmittal letter**
		3.2.1	The Transmittal Letter must be in the form of a letter. The Letter shall include a statement of agreement with the general information in Section 1 and agreement with any requirements/conditions listed in Section 1.
		3.2.2	Summary of ability and desire to supply the required products/services that meet the requirements of Section 3 of the proposal.
		3.2.3	The Letter shall be signed by a person authorized to commit the Respondent to its representations and who can certify that the information offered in the proposal meets all of the general conditions including the information requested in Sections 2, 3, and 4.
		3.2.3	Indication of the principal contact for the proposal along with an address, telephone and fax number as well as an e-mail address, if this contact is different from the individual authorized for signature.
		3.2.5	A statement of acceptance of the contract terms.

Section	TAB	Proposal Reference	Description
2	**2**	**3.3**	**Business proposal**
The Business Proposal must be organized under the specific section titles as listed below.			
	2a	3.3.1	This section may be used to introduce or summarize any information the Respondent deems relevant or important to the State's successful acquisition of the services requested in this RFP.
	2b	3.3.2	Identification of the Respondent's company structure.
	2c	3.3.2	Signatures as necessary to assure that each component of the responding entity legally binds itself to the portions of the proposal for which it is responsible.
	2d	3.3.2	Identification of the legal form of each Respondent's business organization(s), the state in which formed (accompanied by a certificate of authority), the types of business ventures in which the organization(s) is (are) involved, and a chart of the organization(s).
	2f	3.3.3	A statement indicating that the CEO and/or CFO has taken personal responsibility for the thoroughness and correctness of any/all financial information supplied with this proposal. Include how the following are assured: the separation of audit functions from corporate boards and board members, if any, the manner in which the organization assures board integrity, and the separation of audit functions and consulting services.
	2h	3.3.5	A statement describing the status of registration with the Secretary of State.
	2i	3.3.5	A statement describing the status of registration with the Department of Administration.

Section	TAB	Proposal Reference	Description
	2j	3.3.6	Proof that the Respondent's personnel are legally authorized by the organization to commit the organization contractually. (A copy of the corporate by-laws or a corporate resolution adopted by the board of directors indicating this authority will fulfill this requirement.)
	2k	3.3.7	Identification of all subcontractors and a description of the contractual relationship between the Respondent and each subcontractor. (Either a copy of the executed subcontract or a letter of agreement over the official signature of the firms involved must accompany each proposal.)
	2l	3.3.7	Identification of the functions to be provided by the subcontractor and the subcontractor's related qualifications and experience. Also furnish for each subcontractor the anticipated amount of the subcontract, subcontractor's form of organization, the qualifications of the subcontractor for guaranteeing performance, and an indication from the subcontractor of a willingness to carry out these responsibilities. (All subcontracts must be available for inspection and examination by appropriate State officials, and such relationships must be approved by the State.)
	2m	3.3.7	List the subcontractor's name, address and the state in which formed that are proposed to be used in providing the required products or services.
3	**3**	**3.4**	**Technical Proposal**
The Technical Proposal must be organized under the specific section titles as listed below.			
	3a	3.4.1	Provide corporate background and experience for the Respondent; details of

Section	TAB	Proposal Reference	Description
			the background of the company, its size and resources, details of corporate experience relevant to the proposed fiscal agent contract, financial statements and a list of all current or recent Medicaid or related projects in the order specified and identified below.
	3a	3.4.1.1	Corporate background
	3a	3.4.1.2	Corporate financial statements
	3a	3.4.1.3	Corporate experience
	3a	3.4.1.4	Corporate references
	3a	3.4.1.5	Organizational charts
	3a	3.4.1.6	Resumes
	3b	3.4.2	Overall Technical Approach
	3c	3.4.3	Technical approach to implementation planning
	3d	3.4.4	Technical approach to implementation
	3e	3.4.5	Technical approach to operations
	3f	3.4.6	Technical approach to MMIS certification
	3g	3.4.7	Technical approach to turnover
	3h	3.4.8	Data processing
4	**4**	**3.5**	**Cost Proposal**
5	**5**	**3.6**	**Forms**
	5a	3.6.1	In a separate sealed envelope marked **"5a",** Respondents must place all portions of the proposal that are considered to be proprietary, confidential, or otherwise exempt from public disclosure.
	5b	3.6.2	Indiana Economic Impact form
	5c	3.6.3	Buy Indiana Initiative/Indiana Company

Section	TAB	Proposal Reference	Description
	5d	3.14.1	MWBE subcontractor commitment form
	5e	3.14.3	Letter requirement from each WMBE subcontractor
	5f	3.14.4	Respondent acknowledgement
	5g	3.15	Evidence of financial responsibility

3.2 Transmittal Letter

Tab 1 shall be labeled **Transmittal Letter** and include the Transmittal Letter. The Transmittal Letter must address the following topics.

3.2.1 Agreement with Requirement in listed in Section 1

The Respondent must explicitly acknowledge understanding of the general information presented in Section 1 and agreement with any requirements/conditions listed in Section 1. In the Transmittal Letter indicate acceptance of the contract terms.

3.2.2 Summary of Ability and Desire to Supply the Required Products or Services

The Transmittal Letter must briefly summarize the Respondent's ability to supply the requested products and/or services that meet the requirements defined in Section 3 of this RFP. The letter must also contain a statement indicating the Respondent's willingness to provide the requested products and/or services subject to the terms and conditions set forth in the RFP including, but not limited to, the State's contract clauses.

3.2.3 Signature of Authorized Representative

A person authorized to commit the Respondent to its representations and who can certify that the information offered in the proposal is accurate and complete must sign the Transmittal Letter. In the Transmittal Letter, please indicate the principal contact for the proposal along with an address, telephone and fax number as well as an e-mail address, if that contact is different than the individual authorized for signature.

3.2.4 Respondent Notification

The Respondent must indicate an e-mail address in the transmittal letter that will be used for all formal notifications during the procurement process.

It is the Respondent's obligation to notify the Procurement Division of any changes in any address that may have occurred since the origination of this solicitation. The Procurement Division will not be held responsible for incorrect Respondent e-mail or mailing addresses.

3.2.5 Statement of Acceptance of Contract terms

The Transmittal letter should include an affirmative statement that the Respondent accepts all terms and conditions as specified in the State standard contract.

3.3 Business Proposal

Tab 2 shall be labeled **Business Proposal** and shall include a detailed discussion of the Respondent's Business Proposal.

3.3.1 General Overview

This section of the business proposal shall be used to introduce or summarize any information the Respondent deems relevant or important to the State's successful acquisition of the products and/or services requested in this RFP.

3.3.2 Respondent's Company Structure

Each Respondent shall clearly identify the legal makeup of the responding entity, whether it is a single company, a family of companies, or unrelated companies submitting a joint bid. The Respondent shall identify the legal authority of each company represented and provide signatures as necessary to assure that each component of the responding entity legally binds itself to the portions of the proposal for which it is responsible.

Any contract resulting from this procurement must be signed by the identified legal authority for each company represented to adhere to all contract requirements and to perform all work identified to that company subject to any penalty or enforcement rights of the State granted under the contract.

The State reserves the right to reject any bid in which the legal makeup is ambiguous or unclear, in which the signature authority of any company is not clearly explained or in which the signature authority for a company or companies is not given. The State reserves the right to accept any such bid, at the sole discretion of the State, provided the Respondent corrects the deficiency to the satisfaction of the State.

In this section, the Respondent shall identify the legal form of each the Respondent's business organizations, the state in which formed (accompanied by a certificate of authority), the types of business ventures in which the organization is involved, and a chart of the organization are to be included in this section. If the organization includes more than one product division, the division responsible for the development and

marketing of the requested products and/or services in the United States must be described in more detail than other components of the organization

3.3.3 Integrity of Company Structure and Financial Reporting

This section must include a statement indicating that the CEO and/or CFO has taken personal responsibility for the thoroughness and correctness of any/all financial information supplied with this proposal. The particular areas of interest to the State in considering corporate responsibility include the following items: separation of audit functions from corporate boards and board members, if any, the manner in which the organization assures board integrity, and the separation of audit functions and consulting services. The State will consider the information offered in this section to determine the responsibility of the Respondent under IC 5-22-16-1(d).

The Sarbanes Oxley Act of 2002, H.R. 3763, is NOT directly applicable to this procurement; however, its goals and objectives may be used as a guide in the determination of corporate responsibility for financial reports.

3.3.4 Contract Terms/Clauses

A sample of the contract that the state intends to execute with the successful Respondent(s) is provided in Attachment B. All clauses in the sample contract are considered mandatory. If a Respondent objects to any particular clause or its wording, or would like to include additional clauses, this must be indicated by submission of a formal question as provided under Section 2.2.

Otherwise, all clauses from the sample contract will be included and no clauses will be added unless the State, at its sole option, agrees to add, waive or reword any particular clause at the request of the contractor.

In the Transmittal Letter statements required in Section 3.2, the Respondent must indicate acceptance of these mandatory contract terms.

3.3.5 Registration to Do Business

Secretary of State

If awarded the contract, the Respondent will be required to be registered, and be in good standing, with the Secretary of State. The registration requirement is applicable to all limited liability partnerships, limited partnerships, corporations, S-corporations, nonprofit corporations and limited liability companies. The Respondent must indicate the status of registration, if applicable, in this section of the proposal.

Department of Administration, Procurement Division

Additionally, Respondents must be registered with the IDOA. This can be accomplished on-line at www.in.gov/idoa/proc .

The IDOA Procurement Division maintains two databases of contractor information. The Bidder registration database is set up for contractors to register if you are interested in selling a product or service to the State of Indiana. Respondents may register on-line at no cost to become a Bidder with the State of Indiana. To complete the on-line Bidder registration, go to http://www.in.gov/idoa/register/. The Bidder registration offers e-mail notification of upcoming solicitation opportunities, corresponding to the Bidder's area(s) of interest, selected during the registration process. Respondents do need to be registered to bid on and receive e-mail notifications. Completion of the Bidder registration will result in your name being added to the Bidder's Database, for e-mail notification. The Bidder registration requires some general business information, an indication of the types of goods and services you can offer the State of Indiana, and location(s) within the state that you can supply or service. There is no fee to be placed in Procurement Division's Bidder Database. To receive an award, you must be registered as a bidder.

Problems or questions concerning the registration process or the registration form can be e-mailed to Amey Redding, Contractor Registration Coordinator, at aredding@idoa.in.gov, or you may reach her by phone at (317) 234-0234.

3.3.6 Authorizing Document

Respondent personnel signing the Transmittal Letter of the proposal must be legally authorized by the organization to commit the organization contractually. This section shall contain proof of such authority. A copy of corporate bylaws or a corporate resolution adopted by the board of directors indicating this authority will fulfill this requirement.

3.3.7 Subcontractors

The Respondent is responsible for the performance of any obligations that may result from this RFP, and shall not be relieved by the non-performance of any subcontractor. Any Respondent's proposal must identify all subcontractors and describe the contractual relationship between the Respondent and each subcontractor. Either a copy of the executed subcontract or a letter of agreement over the official signature of the firms involved must accompany each proposal.

Any subcontracts entered into by the Respondent must be in compliance with all State statutes, and will be subject to the provisions thereof. For each portion of the proposed products or services to be provided by a subcontractor, the technical proposal must include the identification of the functions to be provided by the subcontractor and the subcontractor's related qualifications and experience.

The combined qualifications and experience of the Respondent and any or all subcontractors will be considered in the State's evaluation. The

Respondent must furnish information to the State as to the amount of the subcontract, the qualifications of the subcontractor for guaranteeing performance, and any other data that may be required by the State. All subcontracts held by the Respondent must be made available upon request for inspection and examination by appropriate State officials, and such relationships must meet with the approval of the State.

The Respondent must list any subcontractor's name; address and the state in which formed that are proposed to be used in providing the required products or services. The subcontractor's responsibilities under the proposal, anticipated dollar amount for subcontract, the subcontractor's form of organization, and an indication from the subcontractor of a willingness to carry out these responsibilities are to be included for each subcontractor. This assurance in no way relieves the Respondent of any responsibilities in responding to this RFP or in completing the commitments documented in the proposal. The Respondent must indicate which, if any, subcontractors qualify as a Minority or Women Owned Business under IC 4-13-16.5-1. See Section 3.14 and Attachment A for Minority and Women Business information.

3.4 Technical Proposal

Tab 3 shall be labeled **Technical Proposal**. The Technical Proposal must be divided into the sections as described below. Every point made in each section must be addressed in the order given. The same outline numbers must be used in the response. RFP language should not be repeated within the response. Where appropriate, supporting documentation may be referenced by a page and paragraph number. However, when this is done, the body of the technical proposal must contain a meaningful summary of the referenced material. The referenced document must be included as an appendix to the technical proposal with referenced sections clearly marked. If there are multiple references or multiple documents, these must be listed and organized for ease of use by the State.

3.4.1 Corporate Background and Experience

Tab 3a shall be labeled **Corporate Background and Experience** and include the corporate background and experience for the Respondent and each subcontractor (if any); details of the background of the company, its size and resources, details of corporate experience relevant to the proposed fiscal agent contract, financial statements, and a list of all current or recent Medicaid or related projects. The specific role of any subcontractor must be identified.

The proposal shall include evidence of the Respondent's and subcontractor's capability by describing its organizational background and experience to include:

3.4.1.1 Corporate Background

Background information of the corporation, its size, and resources shall cover:

1. Name of Respondent or subcontractor;
2. Date established;
3. Ownership (public company, partnership, subsidiary, etc
4. Corporation's Federal Employer's Identification Number (FEIN) and Corporate Charter Number;
5. Corporation's primary line of business;
6. Total number of employees;
7. Number of personnel engaged in computer systems development and operations;
8. Number of personnel engaged in MMIS and DSS systems development and operation; and
9. Computer resources.

3.4.1.2 Corporate Financial Statements

Audited financial statements for the legal contracting entity (and parent company if applicable) and subcontractors, sufficient to demonstrate the capability to perform this contract, shall be provided for each of the last three fiscal years. These shall include:

1. Balance sheets;
2. Statement of income;
3. Statements of changes in financial position;
4. Auditor's reports;
5. Notes to financial statements; and
6. Summary of significant accounting policies.

If all of these are not provided, please explain why.

3.4.1.3 Corporate Experience

The details of corporate experience, to include all Medicaid contracts (including subcontractors), within the last five (5) years, relevant to the proposed fiscal agent contract shall cover:

1. Experience with the operation of a large-scale data processing system (medical claims, MMIS, DSS or otherwise);
2. Experience with multiple benefit plan administration;
3. Experience with Web portal development and operations;

4. Experience with encounter data;
5. Experience with Prescription Benefit Management (PBM) and other benefit management plan development and operations;
6. Experience with Decision Support System (DSS);
7. Experience working directly with managed care providers, HMOs, etc;
8. Experience with enrollment brokering systems;
9. Experience as a fiscal agent or fiscal intermediary; and
10. Experience with other health care systems.

3.4.1.4 Corporate References

For each referenced project, the Respondent and subcontractors shall provide the following items, one project per page. Forms and instructions for references will be provided in the procurement library.

1. Name of Respondent
2. Reference
3. Firm/Agency Name
4. Address
5. Contact Person
6. Name/Title
7. Phone Number
8. Project Dates
9. Title of the Project
10. Start and End Dates of the Original Contract
11. Total Contract Value
12. Average Staff Hours in FTEs During Operations
13. Transaction Processing Volume
14. Brief Description of Scope of Work

3.4.1.5 Organizational Charts

Proposals shall specify the number of experienced staff that will be working on this project and describe the organizational structure. The organizational charts shall include:

1. All proposed individuals for whom resumes are included, identifying their major areas of responsibility during each task, percent of time dedicated to the services required under this contract and location where work will be performed;

2. Total number FTE personnel for each unit, by staff level, for each unit of staff shown on the organizational chart; and

3. Month-by-month minimum commitment staffing levels during the implementation phase of the Contract.

3.4.1.6 Resumes

Individual resumes must be supplied for the Key Staff positions identified for this project. The proposal shall include resumes for the following key staff: project manager, deputy project manager, operations manager, chief financial officer, provider relations, and systems manager. The appropriate resumes for other professionals must be supplied at the State's request. Resumes must show employment history for all relevant and related experience and all education and degrees (including specific dates, names of employers, and educational institutions). Individuals whose resumes are included in the proposal must be available to work on this contract.

The resumes of such personnel proposed shall include:

1. Experience with Respondent (or subcontractor to Respondent), listing the number of years and positions held;
2. Experience with Medicaid claims processing systems;
3. Experience with development and operation of large-scale data processing systems;
4. Project management experience;
5. Experience with other medical claims processing systems;
6. Other data processing experience;
7. Relevant education and training, including college degrees, dates and institution name and location;
8. Names, positions, and phone numbers of a minimum of three clients, within the past five (5) years who can give information on the individual's experience and competence. If the individual has not worked for three different clients in the last five (5) years, provide three references that can give information on the individual's experience and competence. References must not be from employees of the same company; and
9. Each project listed in a resume must include the following:
    a. Full name, title, and (current) telephone number of a client reference for the last five years, including the current project of the staff person;
    b. Start and end dates of the referenced project;
    c. Position(s) of the individual within the project organization; and a brief description of the individual's responsibilities.

3.4.2 Overall Technical Approach

Tab 3b shall be labeled **Overall Technical Approach** and include the Respondent's overall technical approach to the items listed below for each aspect of this contract. The response in this Tab must cover the Respondent's overall technical approach to the requirements specified in this section. At a minimum, discuss the Respondent's general approach to address the requirements in Section 5 as follows:

1. Federal Certification;
2. Cost Allocation Plan;
3. Transparency of Subcontractor Relationships;
4. State Ownership;
5. Contract Amendments;
6. Contractor Personnel;
7. Payment for System Modifications;
8. System Warranty;
9. Performance Monitoring;
10. Record Retention Requirements;
11. Banking Services;
12. Telecommunication Requirements and State Owned Equipment;
13. Access to Libraries;
14. Accounting;
15. Minority Participation Reporting;
16. Force Majeure;
17. Environmental Considerations;
18. HIPAA Compliance;
19. PMBOK®;
20. Information Technology Iterative Project Management;

21. Functional vs. Project Organization;

22. Authority of Project Manager;

23. Project Thresholds;

24. Maintenance of PMO;

25. Separation of Duties:
    a. Financial Control;
    b. Security; and
    c. Quality Control;

26. Functional Management Requirements (for General Operations):
    a. Reporting Status of Operations (Automated Status Reporting);
    b. Reporting Exceptions;
    c. Reporting Staff Levels;
    d. Named Staff Acquisition, Termination, Transfer; and
    e. Quality Control;

27. Project Management Requirements (for Projects):
    a. Project Charter;
    b. Stakeholder Analysis;
    c. Communication Management;
    d. Scope Management;
    e. Risk Management;
    f. Cost Management;
    g. Quality Management;
    h. Staffing Management;
    i. Time Management;
    j. Project Execution and Control;
    k. Integrated Management; and
    l. Status Reporting.

3.4.3 Technical Approach to Implementation Planning

Tab 3c shall be labeled **Technical Approach to Implementation Planning** and include a detailed discussion of the Respondent's approach to the Implementation Planning Phase. The response must address these components of the phase:

3.4.3.1 Data Conversion

1. The Contractor must provide a formal Data Conversion Plan addressing all required elements before Requirements Analysis is complete; and
2. The Contractor must describe in significant detail its approach to data conversion in response to this RFP.

3.4.3.2 Planning

The Contractor must create and submit for State approval a schedule for assumption of all fiscal agent processes and include a draft schedule in response to this RFP.

3.4.3.3 Requirements Analysis

The Contractor must also produce Requirements Analysis documentation, in formats approved by the State;

3.4.3.4 Cooperation with Incumbent

The Respondent must offer a pledge of good faith in working with the incumbent fiscal agent. It must describe the approaches it will use to cooperate with the incumbent, including the methods it will use to document agreements for the delivery of turnover items and the methods it proposes to use to resolve any disputes that may arise with the incumbent.

3.4.3.5 Comprehensive Testing Plan Prior to Contractor Assumption of Incumbent Responsibilities

1. Unit Tests;
2. Structured Data Tests;
3. Volume Tests: The Contractor must use volume simulating tools and methods, and must include a description of its volume testing plan and schedule in response to this RFP;
4. Operations Readiness Tests: The Contractor must include a description of its operations readiness testing strategy, methodology and schedule in response to this RFP;
5. Parallel Tests: The Contractor must include a description of its parallel testing strategy, methodology and schedule in response to this RFP;
6. Beta Tests: The Contractor must describe its approach to Beta testing in response to this RFP;
7. User Acceptance Tests: The Contractor must describe its approach to User Acceptance Testing in response to this RFP;
8. Retesting: The Contractor must include a description of its strategy and methodology for dealing with the situation

where unit tests, structured data tests, operation readiness tests or parallel tests fail to produce the desired results;

3.4.3.6 Risk Analysis and Contingency Planning

The State will place special scoring emphasis on the Contractor's control and management of project risks in this phase of the project;

3.4.3.7 Testing Execution;

3.4.3.8 State Acceptance Testing;

3.4.3.9 Contractor Responsibilities for Implementation Planning Phase;

3.4.3.10 Deliverables Prototypes for each milestone in this phase:

1. Completion of Planning Activities;
2. Completion of Requirements Analysis;
3. Completion of Comprehensive Testing Plan;
4. Completion of Business and Technical Design;
5. Completion of Implementation Planning, Start of Readiness Testing Period; and
6. Conclusion of User Acceptance Testing; and

3.4.3.11 Prototypes of Status and Progress Reports.

3.4.4 Technical Approach to Implementation

Tab 3d shall be labeled **Technical Approach to Implementation** and include a detailed discussion of the Respondent's approach to the Implementation Phase. In its response to this RFP, the Contractor must include a proposed Implementation Schedule covering the following.

1. Implementation;
2. Planning:

   The Contractor must create and submit for State approval a schedule for assumption of all fiscal agent processes and include a draft schedule in response to this RFP;
3. Correction and Adjustment Activities;
4. Execution of Contingency Plans;
5. Implementation of all Components;
6. Deliverables Prototypes for each milestone in this phase:
   a. Implementation schedule;
   b. Documentation of implemented components; and
   c. Ongoing status and progress reports.

3.4.5 Technical Approach to Operations

Tab 3e shall be labeled **Technical Approach to Operations** and include a detailed discussion of the Respondent's approach to the Operations

Phase. The Respondent must acknowledge that it will meet all of the contract requirements that are described in Section 5, Scope of Work. The Contractor must operate IndianaAIM/DSS and perform all functions described in Section 5 from the date of implementation of each component until each function is turned over to a successor fiscal agent at the end of the contract, including any extensions.

Respondents must respond concisely but fully with their approach and how they will comply with the requirements the RFP. The Respondent must respond to all of the requirements in the RFP, explaining their technical approach, identifying tools to be used, describing staffing commitments and explaining in detail how they will meet all requirements. Specifically the Respondent must:

1. **Respond in detail to every item in Section 5;**
2. **Acknowledge all information contained in Sections 5.1 and 5.2;**
3. **Respond in detail to every item under Contractor Responsibilities listed in Section 5.3 through 5.19; and**
4. **Provide the details of staffing for Operations Phase.**

3.4.6 Technical Approach to Maintaining MMIS Certification

Tab 3f shall be labeled **Technical Approach to Maintaining MMIS Certification** and include a detailed discussion of the Respondent's approach to maintaining MMIS certification. The response must address the following components:

1. Planning:
   a. General Planning with State;
   b. Plan to Demonstrate Continued Fulfillment of Federal Requirements; and
   c. Plan to Demonstrate Continued Functional Equivalence.
2. Meetings with Federal and State Certification Team as required or requested and completion of response to questions as applicable.
3. System Remediation:
   a. Correction of Items Not Certified; and
   b. Change Control for Certification.
4. Deliverable Prototypes:
   a. Demonstration Plan; and
   b. Status Reports and other project requirements defined in Section 5, if remediation is required.

3.4.7 Technical Approach to Turnover

Tab 3g shall be labeled **Technical Approach to Turnover** and include a detailed discussion of the Respondent's approach to the Approach to Turnover Phase. The response must address these components of the phase:

1. Planning:
   a. General Planning with State; and
   b. General Planning with Successor.
2. Develop Turnover Plan.
3. Develop IndianaAIM Requirements Statement.
4. Provide Turnover Services:
   a. Cooperation with Successor; and
   b. Turnover of Archived Materials.
5. Contract Closeout Services:
   a. Financial Reconciliation;
   b. Written Assessment of Contract Performance; and
   c. Resolution of Turnover Issues.
6. Approach to Contractor Responsibilities, including:
      a. Contractor staffing;
      b. Contractor facilities;
      c. Contractor resources;
      d. Turnover of IndianaAIM;
      e. Turnover of system documentation;
      f. Turnover training;
      g. Facilitation of successor acceptance testing; and
      h. Final turnover of up-to-date system, data, paper files, and documentation.

3.4.8 Data Processing

Tab 3h shall be labeled **Data Processing** and include the following:

1. Description and location of data and fiscal agent operations facility in Indiana:
   a. List of local hardware/software; and
   b. List of corporate site hardware/software.
2. Location of:
   a. Computer resources;
   b. Back-up and contingency facilities;
   c. System analyst and programmers resources; and
   d. Subcontractors.
3. Approach to system capacity evaluation and planning to address identified issues.
4. Approach Data Processing Standards covering the following areas:
   a. IndianaAIM System Architecture Requirements;
   b. Integration with DSS System Architecture Requirements;
   c. Software/Hardware Configuration;
   d. IndianaAIM Transaction Processing Requirements;

e. Integration with DSS Information Processing Requirements;
f. Programming Language Requirements;
g. System Modification and Change Control Requirements;
h. Application Development and Testing Requirements;
i. Data Imaging and Data Entry Requirements;
j. Data Quality Control;
k. Security and Confidentiality Requirements;
l. Documentation;
m. Continuous Business Process Improvement;
n. State Training Requirements; and
o. Provider Training Requirements.

5. Approach to the use of COTS and Web-based solutions.
6. Approach to imaging and data entry.
7. Telecommunication network description.
8. Approach to security and confidentiality.
9. Approach to documentation; and
10. Approach to procurement of State hardware.

3.5 Cost Proposal

Tab 4 shall be labeled **Cost Proposal**.

3.5.1 Cost Proposal Instructions

Respondents shall propose a firm fixed price for each of the requirements contained on the pricing schedules within this section. All Pricing Schedules provided in this RFP shall be submitted as part of the Cost Proposal. No cost information shall be included in the Technical Proposal. The requirements and schedules are:

1. Summary of Total Proposal (Pricing Schedule A);
2. Operational Price Components (Pricing Schedules B1-B5); and
3. First Steps Price Components (Pricing Schedules C1-C5).

The selected contractor shall be paid for start up costs, not to exceed $5 million, based upon a transition plan approved by the state that details these costs. These costs are not to be included in the costs bid for Operations, First Steps, and the Quality Management Program.

3.5.2 Operations Price

The pricing schedules prepared for IndianaAIM operation shall include all prices for all activities associated with the operation of the system after the operational phase begins, which is January 1, 2008, except for First Steps and the Quality Management Component. The resulting firm fixed price per month (Pricing Schedule A) will be paid upon receipt of approved invoices from the Contractor.

3.5.3 First Steps Price

The pricing schedules prepared for First Steps shall include all prices for all activities specific to First Steps independent of the operations price. The resulting firm fixed price per month (Pricing Schedule A) will be paid upon receipt of approved invoices from the Contractor.

3.5.4 Quality Management Component Price

The Pricing Schedule A shall include the five-year price for all activities associated with the Quality Management program outlined in Sections 5.1.5.21 through 5.1.5.32. Note: The State may elect to procure this program using a separate procurement if that is determined to be in the best interests of the State.

3.5.5 TPL Cost Avoidance and Recovery Percentage

The Pricing Schedule A shall include the percentage for TPL cash recoveries that will be paid to the Contractor.

3.5.6 Signature Block

Where a signature block is indicated, pricing schedules must be signed and dated by an authorized corporate official.

3.5.7 Pricing Schedule A - Summary of Total Proposal

- Line 1 presents the Respondent's Total Price for all five years for operation of the IndianaAIM/DSS excluding tasks specific to First Steps.
- Line 2 presents the Respondent's Price per Month derived from Line 1 divided by 60.
- Line 3 presents the Respondent's Total Price for all five years for all activities specific to First Steps.
- Line 4 presents the Respondent's Price per Month specific to First Steps derived from Line 3 divided by 60.
- Line 5 presents the Respondent's five-year price for the Quality Management Component.
- Line 6 presents the percentage that the Respondent will be paid for cost avoidance and TPL cash recoveries.
- Line 7 presents the modification rates for system modification hours.

3.5.8 Pricing Schedules B-1 through B-5

Instructions for completing Pricing Schedules B-1 through B-5:

1. Respondents shall propose a firm fixed price per month for the contract period. The monthly price will include all costs associated with the operation of the IndianaAIM/DSS described in Section 5 of this RFP (except for costs described in Section 4.5). Payment methodology for Contractor services is described in Section 4.33.

2. Respondents are required to furnish detailed price information used in deriving the proposed price per month for each of the categories and subcategories shown on the detailed Pricing Schedules B-1 through B-5. The Total Price, Line 10 on Schedules B-1 through B-5, is to be reported in Line 1, Columns B through F of Pricing Schedule B. These schedules shall also be used to determine prices that shall be used if the contract is ever amended during the contract period.
3. Respondents are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for the operation of the IndianaAIM/DSS system. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.
4. Telephone prices for equipment and line charges, including toll free lines.
5. If a price category is not already shown on Schedules B-1 through B-5, Line 1 through Line 8, Respondents are to indicate the category under the section headed Other, Line 9. Respondents should list any subcontractor amounts under the section headed Other, Line 9.
6. If the total price for any subcontractor exceeds 10% of the price shown on line 10 for schedules B-1 through B-5 attach a supplemental B schedule for the applicable years in the same format that details and equals the subcontractor price shown on schedules B-1 through B-5. These supplemental schedules B schedules shall also be used, if applicable, if the contract is ever amended for the services provided by the subcontractor.

3.5.9 Pricing Schedules C-1 through C-5

Instructions for completing Pricing Schedules C-1 through C-5:

1. Respondents shall propose a firm fixed price for the contract period specific to First Steps. The monthly price will include all costs associated with the operation of all activities specific to First Steps described in Section 5 of this RFP (except pass through costs as described in Section 4.5). Payment methodology for Contractor services is described in Section 4.33.
2. Respondents are required to furnish detailed price information used in deriving the proposed price per month for each of the categories and subcategories shown on the detailed Pricing Schedules C-1 through C-5. The Total Price, Line 10 on Schedules C-1 through C-5, is to be reported in Line 1, Columns B through F of Pricing Schedule C.

These schedules shall also be used to determine prices that shall be used if the contract is ever amended during the contract period.

3. Respondents are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m specific to First Steps. The prices shown on the schedules are to be the total annual salary and benefits necessary for First Steps activities. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.
4. Telephone prices for equipment and line charges, including toll free lines, if applicable.
5. If a price category is not already shown on Schedules C-1 through C-5, Line 1 through Line 8, Respondents are to indicate the category under the section headed Other, Line 9. Respondents should list any subcontractor amounts under the section headed Other, Line 9.
6. If the total price for any subcontractor exceeds 10% of the price shown on line 10 for schedules C-1 through C-5 attach a supplemental C schedule for the applicable years in the same format that details and equals the subcontractor price shown on schedules C-1 through C-5. These supplemental schedules C schedules shall also be used, if applicable, if the contract is ever amended for the services provided by the subcontractor.

3.5.10 PRICING SCHEDULE A

SUMMARY OF TOTAL PROPOSAL

1. Total of five (5) year operational costs (Line 10, B-1 – B5) $_____
2. Price per month for operational costs (Line 1 divided by 60) $_____
3. Total of five (5) year costs specific to First Steps (Line 10, C-1 – C-5) $_____
4. Price per month specific to First Steps (Line 3 divided by 60) $_____
5. Total of five (5) year costs specific to the Quality Management Component $_____
6. Contingency percentage for TPL cash recoveries _____%

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

3.5.11 PRICING SCHEDULE B-1

OPERATIONAL PRICE COMPONENTS FROM JAN. 1, 2008 - DEC. 31, 2008.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

3.5.12 PRICING SCHEDULE B-2

OPERATIONAL PRICE COMPONENTS FROM JAN. 1, 2009 - DEC. 31, 2009.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

3.5.13 PRICING SCHEDULE B-3

OPERATIONAL PRICE COMPONENTS FROM JAN. 1, 2010 - DEC. 31, 2010.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

3.5.14 PRICING SCHEDULE B-4

OPERATIONAL PRICE COMPONENTS FROM JAN. 1, 2011 - DEC. 31, 2011.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

3.5.15 PRICING SCHEDULE B-5

OPERATIONAL PRICE COMPONENTS FROM JAN. 1, 2012 - DEC. 31, 2012.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

3.5.16 PRICING SCHEDULE C-1

FIRST STEPS PRICE COMPONENTS FROM JAN. 1, 2008 - DEC. 31, 2008.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

3.5.17 PRICING SCHEDULE C-2

FIRST STEPS PRICE COMPONENTS FROM JAN. 1, 2009 - DEC. 31, 2009.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

3.5.18 PRICING SCHEDULE C-3

FIRST STEPS PRICE COMPONENTS FROM JAN. 1, 2010 - DEC. 31, 2010.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

3.5.19 PRICING SCHEDULE C-4

FIRST STEPS PRICE COMPONENTS FROM JAN. 1, 2011 - DEC. 31, 2011.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

3.5.20 PRICING SCHEDULE C-5

FIRST STEPS PRICE COMPONENTS FROM JAN. 1, 2012 - DEC. 31, 2012.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE RESPONDENT MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

3.6 Forms

3.6.1 Confidential Information

In this section, the Respondent must place all portions of its proposal that the Respondent considers to be proprietary, confidential, or otherwise exempt from public disclosure under the terms of Section 3.8 of this RFP. The Respondent must follow the directions of Section 3.8 in the preparation and labeling of confidential material.

3.6.2 Indiana Economic Impact

All companies desiring to do business with state agencies must complete an "Indiana Economic Impact" form (Attachment C). The collection and recognition of the information collected with the Indiana Economic Impact form places a strong emphasis on the economic impact a project will have on Indiana and its residents regardless of where a business is located. The collection of this information does not restrict any company or firm from doing business with the state.

3.6.3 Buy Indiana Initiative/Indiana Company

It is the Respondent's responsibility to confirm its Buy Indiana status for this portion of the process. If a Respondent has previously registered its business with IDOA, go to www.BuyIndiana.In.gov and click on the link to update this registration. Click the tab titled Buy Indiana. Select the appropriate category for your business. Respondents may only select one category. Certify this selection by clicking the check box next to the certification paragraph. Once this is complete, save your selection and exit your account.

Respondents that have not previously registered with IDOA must go to www.BuyIndiana.IN.gov and click on the link to register. During the registration process, follow the steps outlined in the paragraph above to certify your business' status. The registration process should be complete at the time of proposal submission.

Defining an Indiana Business:

"Indiana business" refers to any of the following:

- (Category 1) A business whose principal place of business is located in Indiana.
- (Category 2) A business that pays a majority of its payroll (in dollar volume) to residents of Indiana.
- (Category 3) A business that employs Indiana residents as a majority of its employees.

Respondents claiming this status must indicate which of the provisions above qualifies them as an Indiana business. They must also fully

complete the Indiana Economic Impact Form (Attachment C) and include it with their response.

The following is the policy concerning Categories 4 and 5 described below. Appropriate documentation must be provided with your proposal response supporting either claim made below:

- (Category 4) A business that makes significant capital investments in Indiana.
- (Category 5) A business that has a substantial positive economic impact on Indiana.

Substantial Capital Investment:

Any company that can demonstrate a minimum capital investment of $5 million or more in plant and/or equipment or annual lease payments of $2.5 million or more shall qualify as an Indiana business under category #4. If an out of state company does not meet one of these criteria, it can submit documentation/justification to the State for review for inclusion under this category.

Substantial Indiana Economic Impact:

Any company that is in the top 500 companies (adjusted) for one of the following categories shall qualify as an Indiana business under category #5: number of employees (DWD), unemployment taxes (DWD), payroll withholding taxes (DOR), or Corporate Income Taxes (DOR). If a Respondent needs assistance in determining if its business qualifies under this criterion, please send an e-mail inquiry to buyindianainvest@idoa.in.gov and you will receive a response within forty-eight (48) hours. If an out of state company does not meet one of these criteria, it can submit documentation/justification to the State for review for inclusion under this category.

Pursuant to IC 5-22-15-7, Respondents may claim only one preference. For the purposes of this RFP, this limitation to claiming one preference applies to Respondents' ability to claim the recycled content preference, Indiana small business preference, or to claim eligibility for Buy Indiana points.

3.7 State Sole and Final Arbiter of RFP Requirements

The State is the sole and final arbiter of the requirements described in this RFP. By submitting a proposal, the Respondent acknowledges that the definition or interpretation of the requirements of this RFP is at the sole discretion of the State.

The State reserves the right to classify or reclassify proposal requirements as mandatory or optional if it is in the best interest of the State to do so. The State reserves to itself the sole right to determine whether a bid is responsive or not responsive, and whether any bid should be evaluated.

The State reserves the sole right to determine, as part of the evaluation process, the degree of responsiveness and to assign scores related to any scoring component based on that evaluation.

3.8 Confidential and Proprietary Information

Respondents are advised that materials contained in proposals are subject to the Access to Public Records Act (APRA), IC 5-14-3 *et seq*., and, after the contract award, the entire RFP file may be viewed and copied by any member of the public, including news agencies and competitors. Respondents claiming a statutory exception to the APRA must place all confidential documents (including the requisite number of copies) in a sealed envelope clearly marked "Confidential" and must indicate in the Transmittal Letter and on the outside of that envelope that confidential materials are included. The Respondent must also specify which statutory exception of APRA that applies.

The State reserves the right to make determinations of confidentiality. If the Respondent does not identify the statutory exception, the Procurement Division will not consider the submission confidential. If the State does not agree that the information designated is confidential under one of the disclosure exceptions to APRA, it may seek the opinion of the Public Access Counselor.

Prices are not confidential information.

Information marked Confidential will be evaluated separately, as described in Section 6.

By submitting a proposal, Respondent acknowledges this provision.

3.9 Taxes

Proposals should not include any tax from which the State is exempt.

3.10 Procurement Division Registration

In order to receive an award, you must be registered as a bidder with the Department of Administration, Procurement Division. Therefore, to ensure there is no delay in the award all Respondents are strongly encouraged to register prior to submission of their response. Respondents should go to www.in.gov/idoa/proc and click on "Bidder Registration" to register.

3.11 Secretary of State Registration

If awarded the contract, the Respondent will be required to register, and be in good standing, with the Secretary of State. The registration requirement is applicable to all limited liability partnerships, limited partnerships, corporations, S-corporations, nonprofit corporations and limited liability

companies. Information concerning registration with the Secretary of State may be obtained by contacting:

Secretary of State of Indiana
Corporation Division
402 West Washington Street, E018
Indianapolis, IN 46204
(317) 232-6576
www.in.gov/sos

3.12 Compliance Certification

Responses to this RFP serve as a representation that it has no current or outstanding criminal, civil, or enforcement actions initiated by the State, and it agrees that it will immediately notify the State of any such actions. The Respondent also certifies that neither it nor its principals are presently in arrears in payment of its taxes, permit fees or other statutory, regulatory or judicially required payments to the State.

The Respondent agrees that the State may confirm, at any time, that no such liabilities exist, and, if such liabilities are discovered, that State may bar the Respondent from contracting with the State, cancel existing contracts, withhold payments to setoff such obligations, and withhold further payments or purchases until the entity is current in its payments on its liability to the State and has submitted proof of such payment to the State.

3.13 Equal Opportunity Commitment

Pursuant to IC 4-13-16.5 and in accordance with 25 IAC 5, it has been determined that there is a reasonable expectation of minority and woman business enterprises subcontracting opportunities on a contract awarded under this RFP. Therefore a contract goal of 5 % for Minority Business Enterprises and 5 % for Woman Business Enterprises have been established and all Respondents will be expected to comply with the regulation set forth in 25 IAC 5.

Failure to meet these requirements will affect the evaluation of your proposal.

3.14 Minority and Business Women's Enterprises RFP Subcontractor Commitment

3.14.1 General Requirement

In accordance with 25 IAC 5-5, the Respondent is expected to submit with its proposal a MWBE Subcontractor Commitment Form. The Form must show that there are, participating in the proposed contract, Minority Business Enterprises (MBE) and Women Business Enterprises (WBE) listed in the Minority and Women's Business Enterprises Division

(MWBED) directory of certified firms located at www.buyindinana.in.gov.

If participation is met through use of contractors who supply products and/or services directly to the Respondent, the Respondent must provide a description of products and/or services provided that are directly related to this proposal and the cost of direct supplies for this proposal. Respondents must complete the Subcontractor Commitment Form in its entirety.

Failure to meet these goals will affect the evaluation of your Proposal. The Department reserves the right to verify all information included on the MWBE Subcontractor Commitment Form.

Respondents are encouraged to contact and work with MWBED at 317-232-3061 to design a subcontractor commitment to meet established goals as referenced in this solicitation.

3.14.2 Prime Contractor Assurances related to Subcontractor

Prime Contractors must ensure that the proposed subcontractors meet the following criteria:

3.14.2.1 Proposed subcontractors must be listed on the IDOA Directory of Certified Firms

3.14.2.2 Each firm may only serve as one classification – MBE or WBE

3.14.2.3 A Prime Contractor who is an MBE or WBE must meet subcontractor goals by using other listed certified firms. Certified Prime Contractors cannot count their own workforce or companies to meet this requirement.

3.14.2.4 Proposed subcontractors must serve a commercially useful function. The firm must serve a value-added purpose on the engagement.

3.14.2.5 Proposed subcontractors must provide goods or service only in the industry area for which it is certified as listed in the directory at www.buyindiana.in.gov

3.14.2.6 Proposed subcontractors must be used to provide the goods or services specific to the contract

3.14.2.7 National Corporate Diversity Plans are generally not acceptable

3.14.3 Letter Requirement from each WMBE Subcontractor

A signed letter(s), on company letterhead, from the MBE and/or WBE must accompany the MWBE Subcontractor Commitment Form. Each letter shall state and will serve as acknowledgement from the MBE and/or WBE of its subcontract amount, a description of products and/or services to be provided on this project and approximate date the subcontractor will

perform work on this contract. The State will deny evaluation points if the letter(s) is not attached, not on company letterhead, not signed and/or does not reference and match the subcontract amount and the anticipated period that the Subcontractor will perform work for this solicitation.

3.14.4 Respondent Acknowledgement and Questions

By submission of the Proposal, the Respondent acknowledges and agrees to be bound by the regulatory processes involving the State's MWBE Program. Questions involving the regulations governing the MWBE Subcontractor Commitment Form should be directed to: Minority and Women's Business Enterprises Division at (317) 232-3061 or mwbe@idoa.in.gov.

4 Contractual Requirements

At the beginning of each year, the Indiana Department of Administration issues new boilerplate that includes terms that are required to be included in all state contracts to ensure the legality of the contract. As such, once the final state contract is negotiated, some paragraphs listed under this section may need to be changed due to the authority of the Office of Attorney General, the Indiana Department of Administration, or other governmental bodies or agencies.

4.1 Type and Term of Contract

The State intends to sign a contract with one or more Respondent(s) to fulfill the requirements in this RFP.

The term of the contract shall be for a period of five (5) years from the date of contract execution. There may be up to two (2) one-year renewals, at the State's option.

4.2 State Right to Waive Review of Work Products

The State reserves the right at its sole option to waive review or approval of any particular work product and to waive monitoring of any particular contract provision, including those listed as State Responsibilities in this RFP.

The Contractor shall not use the State's exercise of this waiver as reason to delay performance of any task or requirement specified in this RFP. If at any time the Contractor is being delayed for lack of State action, the Contractor must immediately notify the State by an agreed method. The State may then exercise its waiver under this section, complete the action required, or agree to a modification in schedule.

4.3 Duties of Contractor

The Contractor shall provide the services set forth in the Fiscal Agent Scope of Work from Section 5 of the RFP. The Contractor shall provide services in accordance with the Contractor procedure manuals approved by the State.

4.4 Consideration

The parties agree that the contractor shall be reimbursed a firm fixed price per month. The firm fixed price covers all services in the Fiscal Agent Scope of Work, except for the fees enumerated below and the start up costs described in Section 3.5.1:

4.4.1 The Contractor shall be reimbursed for each year of the Contract for the volume of claims adjudicated to final disposition (paid or denied claims, accepted encounter shadow claims) that exceeds established threshold volumes.

4.4.2 The following rates and claim thresholds have been established for this contract:

Calendar Year	Rate Per Excess Claim	Claim Threshold
2008	$0.093	67,365,000
2009	$0.093	71,407,000
2010	$0.093	75,691,000
2011	$0.093	80,232,000
2012	$0.093	85,046,000

4.4.3 The contractor shall be reimbursed for each year of the contract in which total cost recovery and cost avoidance exceeds established thresholds. The contractor will be reimbursed a maximum of 1% of all dollars collected in excess threshold. Contractors shall propose the contingency percentage in the respective cost proposals. In no case shall the State pay more than $1,500,000 in contingency dollars for each contract year. The total cost recovery and cost avoidance dollars shall be calculated based on the State's current calculation method.

4.4.4 The parties agree to the following thresholds for total cost recovery and cost avoidance:

4.4.4.1 The cost recovery and cost avoidance threshold for 2008 shall be $966,909,128.00.

4.4.4.2 The cost recovery and cost avoidance threshold for subsequent contract years shall be the greater of $966,909,128.00 or the total cost recovery and cost avoidance for any other contract year.

If the active fee-for-service Medicaid population increases by more than five percent (5%) from the FFS as of January 1, 2008, the threshold for Third Party Liability collections will be adjusted by the percent of increase in population.

4.4.5 While the firm fixed price includes all equipment software and communication services required to deliver the services defined in the Fiscal Agent Scope of Work, the Contractor will be reimbursed on a cost basis for all purchases of equipment, software, and communication services approved by the State, which support new services or approved system enhancements. This price does not include purchase of items to support the operations required in this RFP. The Contractor will notify OMPP in advance of any purchases and provide documentation of the contractor's invoiced price. Once agreed to by OMPP, the Contractor will be reimbursed its direct cost. The Contractor shall acquire this equipment through its established channels. Title for all equipment shall pass to the State upon purchase of the equipment. The reimbursement for equipment, software, and communications purchases under this subparagraph for the contract period shall not exceed three hundred thousand dollars ($300,000)

In addition, it is anticipated that the state will require the contractor to secure the services of an Independent Verification and Validation (IV&V) vendor to advise the state on the contractors' success in implementation and operation of various aspects of the system. The state will prior approve the vendor and the terms and conditions of the contract with this vendor, and this vendor will report directly to the state. The state will reimburse the contractor for the cost of this contract.

4.4.6 Hours expended by Modification Pool staff on authorized projects will be charged at the lesser of the billing rates specified in Section 5.15.1.3. or the Cost Proposal Schedules B1-B5 and C1-C5, as applicable.

It is anticipated that the state will require the contractor to conduct a detailed study and possible modifications to the system to support Electronic Medical Records (EMR). The requirements and timing of this study will be finalized with the contractor after operations begin on January 1, 2008. The contractor will be paid according to the terms of this section for this study.

4.5 Access to Records

The Contractor and its subcontractors, if any, shall maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Contract. They shall make such materials available at their respective offices at all reasonable times during this Contract term, and for three (3) years from the date of final payment under this Contract, for inspection by the State or by any other authorized representative of state or federal government. Copies thereof shall be furnished at no cost to the State if requested.

4.6 Assignment

The Contractor binds its successors and assignees to all the terms and conditions of this Contract. The Contractor shall not assign or subcontract the whole or any part of this Contract without the State's prior written consent. The Contractor may assign its right to receive payments to such third parties as the Contractor may desire without the prior written consent of the State, provided that Contractor gives written notice (including evidence of such assignment) to the State thirty (30) days in advance of any payment so assigned. The assignment shall cover all unpaid amounts under this Contract and shall not be made to more than one party.

4.7 Audits

Contractor acknowledges that it may be required to submit to an audit of funds paid through this Contract. Any such audit shall be conducted in accordance with IC 5-11-1, and audit guidelines specified by the State.

4.8 Authority to Bind Contractor

The signatory for the Contractor represents that he/she has been duly authorized to execute contracts on behalf of the Contractor and has obtained all necessary or applicable approvals from the home office of the Contractor, if applicable, to make this Contract fully binding upon the Contractor when his/her signature is affixed, and this Contract is not subject to further acceptance by Contractor when accepted by the State of Indiana.

4.9 Changes in Work

In the event the State requires a major change in the scope, character or complexity of the work after the work has begun, adjustments in compensation to the Contractor shall be determined by the State in the exercise of its honest and reasonable judgment. The Contractor shall not commence any additional work or change the scope of the work until authorized in writing by the State. No claim for additional compensation shall be made in the absence of a prior written approval executed by all signatories hereto.

4.10 Compliance with Laws

4.10.1 The Contractor shall comply with all applicable federal, state and local laws, rules, regulations and ordinances, and all provisions required thereby to be included herein are hereby incorporated by reference. The enactment of any state or federal statute or the promulgation of rules or regulations there under after execution of this Contract shall be reviewed by the State and the Contractor to determine whether the provisions of this Contract require formal modification.

4.10.2 The Contractor and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in Indiana Code § 4-2-6 et seq., the regulations promulgated there under, and Executive Order 04-08, dated April 27, 2004. If the contractor is not familiar with these ethical requirements, the contractor should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission website at http://www.in.gov/ethics/. If the Contractor or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Contract immediately upon notice to the contractor. In addition, the Contractor may be subject to penalties under Indiana Code § 4-2-6-12.

4.10.3 The Contractor certifies by entering into this Contract, that neither it nor its principal(s) is presently in arrears in payment of its taxes, permit fees or other statutory, regulatory or judicially required payments to the State of Indiana. Further, the Contractor agrees that any payments in arrears and currently due to the State of Indiana may be withheld from payments due to the Contractor. Additionally, further work or payments may be withheld, delayed, or denied and/or this Contract suspended until the Contractor is current in its payments and has submitted proof of such payment to the State.

4.10.4 The Contractor warrants that it has no current or pending or outstanding criminal, civil, or enforcement actions initiated by the State of Indiana pending, and agrees that it will immediately notify the State of any such actions. During the term of such actions, Contractor agrees that the State may delay, withhold, or deny work under any Supplement or contractual device issued pursuant to this Contract and any supplements or amendments.

4.10.5 If a valid dispute exists as to the Contractor's liability or guilt in any action initiated by the State of Indiana or its agencies, and the State decides to delay, withhold, or deny work to the Contractor, the Contractor may request that it be allowed to continue, or receive work, without delay. The Contractor must submit, in writing, a request for review to the Indiana Department of Administration (IDOA) following the procedures for disputes outlined herein. A determination by IDOA shall be binding on the parties.

4.10.6 Any payments that the State may delay, withhold, deny, or apply under this section shall not be subject to penalty or interest under IC 5-17-5.

4.10.7 The Contractor warrants that the Contractor and its subcontractors, if any, shall obtain and maintain all required permits, licenses, and approvals, as well as comply with all health, safety, and environmental statutes, rules, or regulations in the performance of work activities for the State. Failure to

do so may be deemed is a material breach of this Contract and grounds for immediate termination of the Agreement and denial of further work with the State.

4.10.8 The Contractor hereby affirms that it is properly registered and owes no outstanding reports with the Indiana Secretary of State.

4.10.9 As required by IC 5-22-3-7:

4.10.9.1 The Contractor and any principals of the Contractor certify that (A) the Contractor, except for de minimis and nonsystematic violations, has not violated the terms of (i) IC 24-4.7 [Telephone Solicitation Of Consumers], (ii) IC 24-5-12 [Telephone Solicitations] , or (iii) IC 24-5-14 [Regulation of Automatic Dialing Machines] in the previous three hundred sixty-five (365) days, even if IC 24-4.7 is preempted by federal law; and (B) the Contractor will not violate the terms of IC 24-4.7 for the duration of the Contract, even if IC 24-4.7 is preempted by federal law.

4.10.9.2 The Contractor and any principals of the Contractor certify that an affiliate or principal of the Contractor and any agent acting on behalf of the Contractor or on behalf of an affiliate or principal of the Contractor: (A) except for de minimis and nonsystematic violations, has not violated the terms of IC 24-4.7 in the previous three hundred sixty-five (365) days, even if IC 24-4.7 is preempted by federal law; and (B) will not violate the terms of IC 24-4.7 for the duration of the Contract, even if IC 24-4.7 is preempted by federal law.

4.11 Condition of Payment

All services provided by the Contractor under this Contract must be performed to the State's reasonable satisfaction, as determined at the discretion of the undersigned State representative and in accordance with all applicable federal, state, local laws, ordinances, rules, and regulations. The State shall not be required to pay for work found to be unsatisfactory, inconsistent with this Contract or performed in violation of any federal, state, or local statute, ordinance, rule or regulation.

4.12 Security and Privacy of Health Information

4.12.1 The Contractor agrees to comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy Regulations that take effect April 14, 2003, and Security Regulations that take effect on April 20, 2005, in all activities related to the contract, to maintain compliance throughout the life of the contract, to operate any systems used to fulfill the requirements of this contract in full compliance

with HIPAA and to take no action which adversely affects the State's HIPAA compliance.

4.12.2 The parties acknowledge that the Department of Health and Human Services (DHHS) has issued the Final Rules, as amended from time to time on the Standards for Privacy of Individually Identifiable Health Information and on the Standards for Security of Individually Identifiable Health Information, as required by the Administrative Simplification Section of HIPAA. The parties acknowledge that the Office is Covered Entity within the meaning of HIPAA. To the extent required by the provisions of HIPAA and regulations promulgated there under, the Contractor assures that it will appropriately safeguard Protected Health Information (PHI), as defined by the regulations, which is made available to or obtained by the Contractor in the course of its work under the contract. The Contractor agrees to comply with all applicable requirements of law relating to PHI with respect to any task or other activity it performs for the Office including, as required by the final Privacy and Security regulations:

4.12.3 Implementing administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Contractor creates, receives, maintains, or transmits on behalf of OMPP;

4.12.4 Implementing a disaster recovery plan, as appropriate, which includes mechanisms to recover data and/or alternative data storage sites, as determined by OMPP to be necessary to uphold integral business functions in the event of an unforeseen disaster;

4.12.5 Not using or further disclosing PHI other than as permitted or required by this Contract or by applicable law;

4.12.6 Using appropriate safeguards to prevent use or disclosure of PHI other than as provided by this Contract or by applicable law;

4.12.7 Reporting to OMPP any security and/or privacy incident of which the Contractor becomes aware;

4.12.8 Mitigating, to the extent practicable, any harmful effect that is known to the Contractor and reporting to the Office any use or disclosure by the Contractor, its agent, employees, subcontractors or third parties, of PHI obtained under this Contract in a manner not provided for by this Contract or by applicable law of which the Contractor becomes aware;

4.12.9 Ensuring that any subcontractors or agents to whom the Contractor provides PHI received from, or created or received by the Contractor, subcontractors or agents on behalf of the Office agree to the same restrictions, conditions and obligations applicable to such party regarding

PHI and agrees to implement reasonable and appropriate safeguards to protect it;

4.12.10 Making the Contractor's internal practices, books and records related to the use or disclosure of PHI received from, or created or received by the Contractor on behalf of the Office available to the Office at its request or to the Secretary of the United States Department of Health and Human Services for purposes of determining the Office's compliance with applicable law. The Contractor shall immediately notify the Office upon receipt by the Contractor of any such request from the Secretary of DHHS, and shall provide the Office with copies of any materials made available in response to such a request;

4.12.11 In accordance with procedures established by the Office, making available the information required to provide an accounting of disclosures pursuant to applicable law, if the duties of the Contractor include disclosures that must be accounted for;

4.12.12 Making available PHI for amendment and incorporating any amendments to PHI in accordance with 45 CFR 164.526, if the Contractor maintains PHI subject to amendment;

4.12.13 In accordance with procedures established by the Office, making PHI available to individuals entitled to access and requesting access in compliance with 45 CFR 164.524 and the duties of the Contractor;

4.12.14 Authorizing termination of the Contract if OMPP determines that the Contractor has violated a material provision; and

4.12.15 At the termination of the Contract, if feasible, return or destroy all PHI received or created under the Contract. If OMPP determines return or destruction is not feasible, the protections in this agreement shall continue to be extended to any PHI maintained by the Contractor for as long as it is maintained.

4.13 Electronic Transaction Standards Compliance

In order to fulfill the terms of this Contract, Contractor will utilize and interface with the State's electronic systems and will use them to perform certain electronic transactions that contain health information, and which are subject to the final rules for the Standards for Electronic Transactions, dated August 17, 2000, under the Administrative Simplification Section of HIPAA (the "Transaction Standards").

The Contractor shall comply with the Transaction Standards, as may be amended from time to time, and shall provide documentation of its compliance with them, including a summary of project plans for remediation, status reports of remediation efforts, summary of text results, copies of certifications, if any, and the Contractor's statement affirming completion of all requirements. Such compliance shall be maintained at no additional cost to the State.

Contractor will indemnify and hold the State harmless from any loss, damage, costs, expense, judgment, sanction or liability, including, but not limited to, attorneys' fees and costs, that the State incurs or is subject to, as a result of Contractor's breach of this Paragraph.

4.14 Confidentiality of Data, Property Rights in Products, and Copyright Prohibition

The Contractor agrees that all information, data, findings, recommendations, proposals, etc. by whatever name described and in whatever form secured, developed, written or produced by the Contractor in furtherance of this Contract shall be the property of the State. The Contractor shall take such action as is necessary under law to preserve such confidentiality and property rights in and of the State while such property is within the control and/or custody of the Contractor. The Contractor hereby specifically waives and/or releases to the State any cognizable property right of the Contractor to copyright, license, patent or otherwise use of such information, data, findings, recommendations, proposals, etc.

4.15 Confidentiality of State Information

The Contractor understands and agrees that data, materials, and information disclosed to Contractor may contain confidential and protected data. Therefore, the Contractor promises and assures that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, will not be disclosed to others or discussed with third parties without the prior written consent of the State.

4.16 Conflict of Interest

As used in this section:

- "Immediate family" means the spouse and the unemancipated children of an individual.
- "Interested party," means:
  - The individual executing this contract;
  - An individual who has an interest of three percent (3%) or more of Contractor, if Contractor is not an individual; or
  - Any member of the immediate family of an individual specified under subdivision 1 or 2.
- "Department" means the Indiana Department of Administration.
- "Commission" means the State Ethics Commission.

4.16.1 The Department may cancel this Contract without recourse by Contractor if any interested party is an employee of the State of Indiana.

4.16.2 The Department will not exercise its right of cancellation under section B above if the Contractor gives the Department an opinion by the Commission indicating that the existence of this Contract and the employment by the State of Indiana of the interested party does not violate any statute or rule relating to ethical conduct of state employees. The Department may take action, including cancellation of this Contract consistent with an opinion of the Commission obtained under this section.

4.16.3 Contractor has an affirmative obligation under this Contract to disclose to the Department when an interested party is or becomes an employee of the State of Indiana. The obligation under this section extends only to those facts that Contractor knows or reasonably could know.

4.17 Continuity of Services

The Contractor recognizes that the services under this contract are vital to the State and must be continued without interruption and that, upon contract expiration, a successor, either the State or another Contractor, may continue them.

4.17.1 The Contractor agrees to provide the Turnover Services.

4.17.1.1 Regardless of the reason for termination, the Contractor agrees to provide no less than the following: 1) furnish phase-in training and 2) exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.

4.17.1.2 The Contractor shall, upon the State's written notice furnish phase-in, phase-out services for up to sixty (60) days after this contract expires; and

4.17.1.3 The Contractor shall, upon the State's written notice negotiate in good faith a plan with a successor to determine the nature and extent of phase-in, phase-out services required.

This plan shall specify a training program and a date for transferring responsibilities for each division of work described in the plan, and shall be subject to the State's approval. The Contractor shall provide sufficient experienced personnel during the phase-in, phase-out period to ensure that the services called for by this contract are maintained at the required level of proficiency.

4.17.2 The Contractor shall agree to waive certain employment restrictions applicable to dedicated on-site employees to allow as such personnel to accept employment with the successor contractor. Such waiver shall not include any waiver of any employment agreement restrictions relating to

the protection and non-disclosure of Contractor confidential and/or trade secret information. However, all knowledge gained through the support of this contract shall not be considered confidential and / or trade secret information. The Contractor also shall cooperate with the successor in its efforts to recruit these employees (i.e. inform staff of job fairs). If selected employees are agreeable to the change, the Contractor shall release them at a mutually agreeable date, and negotiate transfer of their earned fringe benefits to the successor.

4.17.3 The Contractor shall be reimbursed for all reasonable phase-in, phase-out costs (i.e., costs incurred that exceed Turnover Services described in the Statement of Work or additional services provided within the agreed period after contract expiration that result from phase-in, phase-out operations).

4.18 Debarment and Suspension

Contractor certifies, by entering into this Contract, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Contract by any federal agency or by any department, agency or political subdivision of the State of Indiana. The term "principal" for purposes of this Contract means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence on or substantive control over the operations of Contractor.

The Contractor also further certifies that it has verified the suspension and debarment status for all sub-contractors receiving funds under this Contract and shall be solely responsible for any recoupments, paybacks and or penalties that might arise from non-compliance. Contractor shall immediately notify the State if any sub-contractor becomes debarred or suspended, and shall, at the State's request, take all steps required by the State to terminate its contractual relationship with the sub-contractor for work to be performed under this Contract.

4.19 Default by State

If the State, sixty (60) days after receipt of written notice, fails to correct or cure any breach of this Contract, then the Contractor may cancel and terminate this Contract and collect all monies due up to and including the date of termination.

4.20 Actual and Liquidated Damages

Damage may be sustained by the State in the event that the Contractor fails to meet the requirements of this contract. If the damages can be measured in actual cost, it is referred to as actual damages. If the damages are difficult to measure or cannot be measured in actual cost, it is referred

to as liquidated damages. In the event of default or the inability to maintain minimum standards as determined by the State, the Contractor agrees to pay the State for the actual cost of damages or the sums set forth below as liquidated damages. Liquidated damages are considered compensation for increase contract management and do not constitute a penalty.

4.20.1 Transfer of Named Staff Proposed

4.20.1.1 Requirements

The Contractor will maintain all Named Staff proposed for two years from the start of Operations Phase. Only after the first two years of operations will the Contractor be allowed to request the replacement of any Named Staff, subject to prior approval of the State.

4.20.1.2 Liquidated Damages

If any Named Staff are replaced without approval during any phase of the contract, or in the first two years of operations, other than at the request of the State or voluntary termination of the staff member's employment with the Contractor, liquidated damages equal to $500 per remaining workday for each Named Staff shall be assessed.

4.20.2 Named Staff Vacancy

4.20.2.1 Requirements

Positions that are designated as Named Staff shall not remain vacant for more than thirty (30) calendar days. Named Staff positions shall not be filled with employees who are acting in a temporary capacity and also maintain responsibilities for another position.

4.20.2.2 Liquidated Damages

The liquidated damages will be $500 per workday for each day that the Contractor fails to meet this requirement.

4.20.3 Staffing Levels

4.20.3.1 Requirements

The Contractor will maintain the minimum number and levels of qualified staff specified in its proposal and, in all other respects meet the staffing requirements of this RFP.

4.20.3.2 Liquidated Damages

Staffing levels and rate of pay are subject to State audit at any time during the Operations Phase of the contract. If the audit reveals staffing more than five percent (5%) below the requirement of the contract actual damages will be assessed according to the cost in the appropriate Schedule B or C for each FTE below the standard.

4.20.3.3 Actual Damages

The Contractor will be assessed the difference between the rate of pay for an employee and the appropriate Schedule B or C as determined by a payroll audit.

4.20.4 Provider Activation Prior to Meeting Eligibility Requirements

4.20.4.1 Requirements

The Contractor is responsible for enrolling providers according to the rules established by the State that include but are not limited to: licensure, background check, and site visits.

4.20.4.2 Actual Damages

The Contractor will be assessed actual damages that result from the enrollment of a provider that has not met all the enrollment requirements.

4.20.5 System Certification and Performance Review

4.20.5.1 Requirements

The Contractor will ensure that MMIS federal certification (or its equivalent) is achieved and continued throughout Operation Phase of the MMIS by the Contractor. In the event that the CMS determines that a new certification process is necessary, the Contractor will ensure for their designated functions that all such certification requirements are met and that the new certification is retroactive to the date on which certification was discontinued should such discontinuation occur.

The Contractor is responsible for meeting any new or modified federal standards, conditions or functional requirements for the operation of the MMIS.

The Contractor will be responsible for ensuring that federal MMIS certification and recertification requirements established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) are met, and that maximum allowable Federal Financial Participation (FFP) is granted. Should the Contractor identify at any time any area in which certification or recertification requirements may not be met or any reason for which maximum FFP would not be granted, the Contractor will notify the State of the deficiency, present corrective action plans and upon approval by the State, correct the deficiency.

The Contractor will provide all support requested by the State during certification and any recertification conducted by CMS and by the State. The support will include assisting the State and CMS in sample selections, document and data gathering, and responding to CMS and State questions.

4.20.5.2 Actual Damages

The Contractor will be liable for the difference between the maximum allowable federal financial participation (FFP) and that actually received by the State for the operation of the MMIS as required by certification standards that is attributable to performance or non-performance of the Contractor.

4.20.6 Systems Documentation

4.20.6.1 Requirements

The Contractor is responsible for providing to the State complete, accurate, and timely documentation of the operational MMIS. In addition to the required hard copies, the MMIS documentation will be maintained on the Contractor's Web portal.

Six copies of updated documentation and online documentation must be provided to the State in final form within sixty (60) workdays prior to the beginning of the operations task.

The Contractor must update documentation with all modifications and modernizations that are made to the system after the initial delivery of the documentation. Six copies of updated documentation must be provided to the State in final form within fifteen (15) workdays of the State's approval of the implementation of the change. Online documentation must be posted within three (3) workdays of the State's approval of the documentation.

4.20.6.2 Liquidated Damages

The liquidated damages will be one hundred dollars ($100) for each workday that documentation is not submitted or is unacceptable to the State.

4.20.7 Medicare Premium Liability

4.20.7.1 Requirements

The State's Medicare premium liability must be paid to CMS in accordance with U.S. Department of Health and Human Services State Buy-In Manual, Pub. 100-15, contained in the Medicaid Procurement Library.

4.20.7.2 Actual Damages

The actual damages will be equal to the charges assessed to the State by CMS in accordance with the U.S. Department of Health and Human Services State Buy-In Manual, Pub. 100-15 contained in the Medicaid Procurement Library.

4.20.8 Correctness of Payments

All payments made through MMIS must be made on behalf of eligible recipients, to enrolled, eligible providers, for approved services, and in accordance with the payment rules and other policies of the State.

4.20.8.1 Actual Damages

If an overpayment or duplicate payment is made to a provider or any other entity and that payment is the result of Contractor error then the Contractor will be liable for the immediate reimbursement to the State for the actual overpayment or duplicate payment. The Contractor has the right to recover such overpayments or duplicate payments.

4.20.9 Data Conversion

4.20.9.1 Requirements

The Contractor must convert all data from the State's existing MMIS necessary to operate MMIS and produce comparative reports for previous periods of operation. Data conversion must be completed before the five-month parallel and user acceptance testing period begins, and must be applied before implementation.

4.20.9.2 Liquidated Damages

The liquidated damages will be one thousand dollars ($1,000) for each workday that data conversion is not completed or applied as stated above. Data conversion must be approved by the State before it is considered complete and before it is applied.

4.20.10 Data Communications

The Contractor will provide continuous twenty-four (24) hour connection to the State's network. Failure to provide this connection must be remedied immediately upon notification by the State.

4.20.10.1 Liquidated Damages

The liquidated damage for failure to remedy a lack of network connection will be one thousand dollars ($1,000) per hour after four (4) hours of State notification, if lack of connection occurs as a result of Contractor error or omission.

4.20.11 Back Up Site/Data

4.20.11.1 Requirements

In the event of a natural or man-made disaster all data/files must be protected in an off-site location. The Contractor must provide an alternate business site if the primary business site becomes unsafe or inoperable. The business site must be fully operational within five (5) workdays of the primary business becoming unsafe or inoperable.

4.20.11.2 Liquidated Damages

The liquidated damages for failure to provide the back up site/data will be $10,000 per day for each day that the back up site is not fully operational.

4.20.12System Capacity

4.20.12.1 Requirements

The Contractor must maintain the system capacity to operate MMIS without interruption, except for scheduled down-time, and meet all operational requirements and process all claims and transactions in a timely manner. The following are indications that the system is operating below capacity:

- Delays or interruptions in the operation of MMIS and related services caused by inadequate equipment or processing capacity.
- System not available for use by State or Contractor staff at all times except for scheduled downtime.
- Inability to adjudicate to a paid, denied, or suspended status, all claims received by the Contractor within twenty-four (24) hours of receipt.
- Frequent delays of more than five (5) seconds in screen response time.

4.20.12.2 Liquidated Damages

The State will notify the Contractor if the system is operating below capacity based on these measurements. If the Contractor fails to correct the capacity issues within two (2) workdays liquidated damages will be assessed at $2,000 per day.

The Contractor must maintain the system capacity to complete all jobs in a scheduled cycle. The processing cycle must be completed each night to allow the system to be available each morning by 7:00 a. m. Eastern time, for inquiry and update.

Two hundred and fifty dollars ($250) each occurrence for each job eliminated from a scheduled cycle if the eliminated job is not processed in the next scheduled cycle.

4.20.13HIPAA Compliance

4.20.13.1 Requirements

The Contractor must ensure it meets all federal regulations regarding standards for privacy, security, and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The Contractor must deliver, maintain and operate MMIS in full compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The Contractor is responsible for HIPAA compliance of MMIS and the fiscal operations regardless of its status as a covered entity or business associate of the State.

4.20.13.2 Actual Damages

The actual damages for the Contractor's failure to comply with the HIPAA standards shall be any penalties that the State is assessed.

4.20.14 Correction of Deficiencies Identified by the State

4.20.14.1 Requirements

If the State identifies deficiencies in the Contractor's performance of requirements as described in the RFP, not otherwise addressed in other liquidated or actual damages provisions, the State will require the Contractor to develop a corrective action plan within ten (10) workdays. The corrective action plan will be reviewed by the State within five (5) workdays and modified by the Contractor in five (5) workdays.

4.20.14.2 Liquidated Damages

The liquidated damages shall be equal to $500 per day for each day that the corrective action plan is late or not acceptable to the State and $1,000 per day for each day that the deficiency is not corrected, past the date specified in the corrective action plan or not acceptable to the State.

4.20.15 Deduction of Damages from Payments

4.20.15.1 Liquidated Damages

Amounts due the State as liquidated damages may be deducted by the State from any money payable to the Contractor pursuant to this contract. The State will notify the Contractor in writing of any claim for liquidated damages at least thirty (30) calendar days prior to the date the State deducts such sums from money payable to the Contractor. Such amounts as they relate to Section 30 may be deducted during the entire period that MMIS certification is lacking. Should certification subsequently be granted retroactively, the State will reimburse the Contractor for any amounts that have been withheld due to lack of certification.

4.20.15.2 Actual Damages

Amounts due the State as actual damages may be deducted by the State from any money payable to the Contractor pursuant to this contract. The State will notify the Contractor in writing on or before the date the State deducts such sums from money payable to the Contractor. Such amounts as they relate to Section 30 may be deducted from amounts currently payable to the Contractor.

4.21 Disputes

4.21.1 Should any disputes arise with respect to this Contract, Contractor and the State agree to act immediately to resolve such disputes. Time is of the essence in the resolution of disputes.

4.21.2 The Contractor agrees that, the existence of a dispute notwithstanding, it will continue without delay to carry out all its responsibilities under this Contract that are not affected by the dispute. Should the Contractor fail to continue to perform its responsibilities regarding all non-disputed work, without delay, any additional costs incurred by the State or the Contractor as a result of such failure to proceed shall be borne by the Contractor, and the Contractor shall make no claim against the State for such costs.

4.21.3 If the State and the Contractor cannot resolve a dispute within ten (10) working days following notification in writing by either party of the existence of a dispute, then the following procedure shall apply:

The parties agree to resolve such matters through submission of their dispute to the Commissioner of the Indiana Department of Administration. The Commissioner shall reduce a decision to writing and mail or otherwise furnish a copy thereof to the Contractor and the State within ten (10) working days after presentation of such dispute for action. The Commissioner's decision shall be final and conclusive unless either party mails or otherwise furnishes to the Commissioner, within ten (10) working days after receipt of the Commissioner's decision, a written appeal. Within ten (10) working days of receipt by the Commissioner of a written request for appeal, the decision may be reconsidered. If no reconsideration is provided within ten (10) working days, the parties may mutually agree to submit the dispute to arbitration for a determination, or otherwise the dispute may be submitted to an Indiana court of competent jurisdiction.

4.21.4 The State may withhold payments on disputed items pending resolution of the dispute. The unintentional nonpayment by the State to the Contractor of one or more invoices not in dispute in accordance with the terms of this Contract will not be cause for Contractor to terminate this Contract, and the Contractor may bring suit to collect these amounts without following the disputes procedure contained herein.

4.22 Drug-Free Workplace Certification

The Contractor hereby covenants and agrees to make a good faith effort to provide and maintain a drug-free workplace. Contractor will give written notice to the State within ten (10) days after receiving actual notice that the Contractor or an employee of the Contractor has been convicted of a criminal drug violation occurring in the contractor's workplace.

False certification or violation of the certification may result in sanctions including, but not limited to, suspension of contract payments, termination

of this Contract and/or debarment of contracting opportunities with the State of Indiana for up to three (3) years.

In addition to the provisions of the above paragraphs, if the total contract amount set forth in this Contract is in excess of $25,000.00, Contractor hereby further agrees that this agreement is expressly subject to the terms, conditions, and representations of the following certification:

4.22.1.1 This certification is required by Executive Order No. 90-5, April 12, 1990, issued by the Governor of Indiana. Pursuant to its delegated authority, the Indiana Department of Administration is requiring the inclusion of this certification in all contracts and grants from the State of Indiana in excess of $25,000.00. No award of a contract shall be made, and no contract, purchase order or agreement, the total amount of which exceeds $25,000.00, shall be valid, unless and until this certification has been fully executed by the Contractor and made a part of the contract or agreement as part of the contract documents.

4.22.1.2 The Contractor certifies and agrees that it will provide a drug-free workplace by:

4.22.1.3 Publishing and providing to all of its employees a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace, and specifying the actions that will be taken against employees for violations of such prohibition;

4.22.1.4 Establishing a drug-free awareness program to inform it's employees of (1) the dangers of drug abuse in the workplace; (2) the Contractor's policy of maintaining a drug-free workplace; (3) any available drug counseling, rehabilitation, and employee assistance programs; and (4) the penalties that may be imposed upon an employee for drug abuse violations occurring in the workplace;

4.22.1.5 Notifying all employees in the statement required by subparagraph (A) above that as a condition of continued employment, the employee will (1) abide by the terms of the statement; and (2) notify the Contractor of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

4.22.1.6 Notifying in writing the State within ten (10) days after receiving notice from an employee under subdivision (C)(2) above, or otherwise receiving actual notice of such conviction;

4.22.1.7 Within thirty (30) days after receiving notice under subdivision (C)(2) above of a conviction, imposing the following sanctions or remedial measures on any employee who is convicted of drug abuse violations occurring in the workplace: (1) taking appropriate personnel action against the employee, up to and including termination; or (2) requiring such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state or local health, law enforcement, or other appropriate agency; and

4.22.1.8 Making a good faith effort to maintain a drug-free workplace through the implementation of subparagraphs (A) through (E) above.

4.23 Employment Option

If the State determines that it would be in the State's best interest to hire an employee of the Contractor, the Contractor will release the selected employee from any non-compete agreements that may be in effect. This release will be at no cost to the State or the employee. Additionally, if the State determines that it would be in the State's best interest to pursue direct contracting with a sub-contractor of the Contractor, the Contractor will release the sub-contractor from any non-compete agreements that may be in effect. This release will be at no cost to the State or the sub-contractor.

4.24 Force Majeure

In the event that either party is unable to perform any of its obligations under this Contract or to enjoy any of its benefits because of natural disaster or decrees of governmental bodies not the fault of the affected party (hereinafter referred to as a "Force Majeure Event"), the party who has been so affected shall immediately give notice to the other party and shall do everything possible to resume performance. Upon receipt of such notice, all obligations under this Contract shall be immediately suspended. If the period of nonperformance exceeds thirty (30) days from the receipt of notice of the Force Majeure Event, the party whose ability to perform has not been so affected may, by giving written notice, terminate this Contract.

4.25 Funding Cancellation

When the Director of the State Budget Agency makes a written determination that funds are not appropriated or otherwise available to support continuation of performance of this Contract, this Contract shall be canceled. A determination by the Budget Director that funds are not appropriated or otherwise available to support continuation of performance shall be final and conclusive.

4.26 Governing Laws

This Contract shall be construed in accordance with and governed by the laws of the State of Indiana and suit, if any, must be brought in the State of Indiana.

4.27 Indemnification

The Contractor agrees to indemnify, defend, and hold harmless the State, its agents, officers, and employees from all claims and suits including court costs, attorney's fees, and other expenses caused by any act or omission of the Contractor and/or its subcontractors, if any, in the performance of this Contract. The State shall not provide such indemnification to the Contractor.

4.28 Independent Contractor

Both parties hereto, in the performance of this Contract, shall act in an individual capacity and not as agents, employees, partners, joint ventures or associates of one another. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purposes whatsoever. Neither party will assume liability for any injury (including death) to any persons, or damage to any property arising out of the acts or omissions of the agents, employees or subcontractors of the other party.

The Contractor shall be responsible for providing all necessary unemployment and workers' compensation insurance for the Contractor's employees.

4.29 Information Technology Accessibility

If Contractor provides any information technology related products or services to the State, Contractor shall comply with all Indiana Office of Technology (IOT) standards, policies, and guidelines, which are online at http://iot.in.gov/architecture/. Contractor specifically agrees that all hardware, software, and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information technology accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 U.S.C. 794d) and IC 4-13.1-3. Any deviation from these architecture requirements must be approved in writing by IOT in advance. The State may terminate this Contract for default if Contractor fails to cure a breach of this provision within a reasonable time.

The Contractor acknowledges and agrees that all hardware, software and services provided to or purchased by the State must be compatible with the principles and goals contained in the electronic and information technology accessibility standards adopted by the Architectural and

Transportation Barriers Compliance Board under Section 508 of the Federal Rehabilitation Act of 1973 (29 U.S.C. 749d), as amended, and adopted by the State of Indiana Office of Technology pursuant to IC 4-23-16-12.

4.30 Insurance

4.30.1 The Contractor shall secure and keep in force during the term of this Contract, the following insurance coverages, covering the Contractor for any and all claims of any nature which may in any manner arise out of or result from this Contract:

4.30.1.1 Commercial general liability, including contractual coverage, and products or completed operations coverage (if applicable), with minimum liability limits of $700,000 per person and $5,000,000 per occurrence unless additional coverage is required by the State.

4.30.1.2 Automobile liability with minimum liability limits of $700,000 per person and $5,000,000 per occurrence.

4.30.1.3 The Contractor shall provide proof of such insurance coverage by tendering to the undersigned State representative a certificate of insurance prior to the commencement of this Contract and proof of Workers compensation coverage meeting all statutory requirements of IC 22-3-2. In addition, proof of an "all states endorsement" covering claims occurring outside the State is required if any of the services provided under this Contract involve work outside of Indiana.

4.30.2 The Contractor's insurance coverage must meet the following additional requirements:

4.30.2.1 The insurer must have a certificate of authority issued by the Indiana Department of Insurance.

4.30.2.2 Any deductible or self-insured retention amount or other similar obligation under the insurance policies shall be the sole obligation of the Contractor.

4.30.2.3 The State will be defended, indemnified and held harmless to the full extent of any coverage actually secured by the Contractor in excess of the minimum requirements set forth above. The duty to indemnify the State under this Contract shall not be limited by the insurance required in this Contract.

4.30.2.4 The insurance required in this Contract, through a policy or endorsement(s), shall include a provision that the policy and endorsements may not be canceled or modified without thirty (30) days' prior written notice to the undersigned State agency.

4.30.2.5 Failure to provide insurance as required in this Contract may be deemed a material breach of contract entitling the State to immediately terminate this Contract.

The Contractor shall furnish a certificate of insurance and all endorsements to the undersigned State agency prior to the commencement of this Contract.

4.31 Key Persons

4.31.1 If both parties have designated that certain individual(s) are essential to the services offered, the parties agree that should such individual(s) leave their employment during the term of this Contract for whatever reason, the State shall have the right to terminate this Contract upon thirty (30) days prior written notice.

4.31.2 In the event that the Contractor is an individual, that individual shall be considered a key person and, as such, essential to this Contract. Substitution of another for the Contractor shall not be permitted without express written consent of the State.

4.31.3 Nothing in sections A and B, above shall be construed to prevent the Contractor from using the services of others to perform tasks ancillary to those tasks which directly require the expertise of the key person. Examples of such ancillary tasks include secretarial, clerical, and common labor duties. The Contractor shall, at all times, remain responsible for the performance of all necessary tasks, whether performed by a key person or others. Any key person or persons will be identified at the time of contract execution.

4.32 Licensing Standards

The parties agree that Contractor and its employees and subcontractors shall comply with all applicable licensing standards, certification standards, accrediting standards and any other laws, rules or regulations governing services to be provided by the Contractor pursuant to this Contract. The State shall not be required to reimburse Contractor for any services performed when Contractor or its employees or subcontractors are not in compliance with such applicable standards, laws, rules or regulations. If licensure, certification or accreditation expires or is revoked, Contractor shall notify State immediately and the State, at its option, may immediately terminate this Contract.

4.33 Merger and Modification

This Contract constitutes the entire agreement between the parties. No understandings, agreements, or representations, oral or written, not specified within this Contract will be valid provisions of this Contract.

This Contract may not be modified, supplemented or amended, in any manner, except by written agreement signed by all necessary parties.

4.34 Minority and Women's Business Enterprises Compliance

The Contractor agrees to comply fully with the provisions of 25 IAC 5 and any participation plan that may have been submitted to the State.

The Contractor will be required to identify each MBE and WBE listed on the Minority and Women's Business Enterprises Division directory of certified firms that will be participating in this Contract. For each participating MBE/WBE the Contractor will be required to list:

- Phone number
- Company name
- Scope of product(s) and/or service(s)
- Utilization date
- Amount

4.35 Nondiscrimination

Pursuant to IC 22-9-1-10 and the Civil Rights Act of 1964, Contractor and its subcontractors shall not discriminate against any employee or applicant for employment in the performance of this Contract. The Contractor shall not discriminate with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of race, color, religion, sex, disability, national origin or ancestry. Breach of this covenant may be regarded as a material breach of this Contract. The Contractor's execution of this Contract also signifies compliance with applicable federal laws, regulations, and executive orders prohibiting discrimination in the provision of services based on race, color, national origin, age, sex, disability or status as a veteran.

The Contractor understands that the State is a recipient of federal funds. Pursuant to that understanding, the Contractor and its subcontractor, if any, agree that if the Contractor employs fifty (50) or more employees and does at least $50,000.00 worth of business with the State and is not exempt, the Contractor will comply with the affirmative action reporting requirements of 41 CFR 60-1.7. The Contractor shall comply with Section 202 of Executive Order 11246, as amended, 41 CFR 60-250, and 41 CFR 60-741, as amended, which are incorporated herein by specific reference. Breach of this covenant may be regarded as a material breach of this Contract.

4.36 Notices

The Contractor and State will be required, at the time the contract is executed, to identify where notices shall be sent. Whenever any notice,

statement or other communication is required under this Contract, it shall be sent to the following addresses unless otherwise specifically advised:

The State will be required to identify:
Program Contact
Title
Office of Medicaid Policy and Planning (or other office as appropriate)
402 West Washington Street, Room W 382
Indianapolis, IN 46204

The Contractor will be required to identify:
Contact name & Title
Agency Name
Specific Address
TIN/FIN #

4.36.1 As required by IC 4-13-2-14.8, payments to the Contractor shall be made via electronic funds transfer in accordance with instructions filed by the Contractor with the Indiana Auditor of State.

4.37 Order of Precedence

Any inconsistency or ambiguity in this Contract shall be resolved by giving precedence in the following order: (1) This Contract, (2) Attachments Prepared by the State, (3) The RFP (4) Contractor's Proposal.

4.38 Ownership of Documents and Materials

All documents, records, programs, data, film, tape, articles, memoranda, and other materials not developed or licensed by the Contractor prior to execution of this Contract, but specifically developed under this Contract shall be considered "work for hire" and the Contractor transfers any ownership claim to the State of Indiana and all such materials will be the property of the State of Indiana. Use of these materials, other than related to contract performance by the Contractor, without the prior written consent of the State, is prohibited. During the performance of this Contract, the Contractor shall be responsible for any loss of or damage to these materials developed for or supplied by the State and used to develop or assist in the services provided herein while the materials are in the possession of the Contractor. Any loss or damage thereto shall be restored at the Contractor's expense. Full, immediate, and unrestricted access to the work product of the Contractor during the term of this Contract shall be available to the State.

4.39 Payments

4.39.1 The Office will provide the above-specified funding on a reimbursement basis, with the Contractor submitting claims directly to the office specified by the State of Indiana.

The Contractor will be paid a fixed rate for activities/services performed and must submit an invoice that is accompanied by a monthly report documenting the contracted activities, including the following:

The charges for the activities/services as specified in the Statement of Work or workplan.

The name and telephone number of the individual who can provide clarification or answers about the invoice or monthly report must be listed. If the individual is different for each report, please specify.

4.39.2 All invoices must be received by the Office by the tenth (10th) day of the month following the month which is being billed to insure payment at the end of that month.

4.39.3 All invoices must be received by the Office within sixty (60) days after the date costs are incurred, or the claims for payment will be denied.

4.39.4 All invoices must be received by the Office within sixty (60) days after the expiration date of the contract, or the claims for payment will be denied.

4.39.5 All payments shall be made in arrears in conformance with State fiscal policies and procedures and, as required by IC 4-13-2-14.8, by electronic funds transfer to the financial institution designated by the Contractor in writing unless a specific waiver has been obtained from the Auditor of State. No payments will be made in advance of receipt of the goods or services that are the subject of this Contract except as permitted by IC 4-13-2-20.

4.39.6 It is understood and agreed upon by the parties that all obligations of the State of Indiana are contingent upon the availability and continued appropriation of State and Federal funds, and in no event shall the State of Indiana be liable for any payments in excess of available appropriated funds.

4.40 Penalties/Interest/Attorney's Fees

The State will in good faith perform its required obligations hereunder and does not agree to pay any penalties, liquidated damages, interest, or attorney's fees, except as required by Indiana law, in part, IC 5-17-5, IC 34-54-8, and IC 34-13-1.

Notwithstanding the provisions contained in IC 5-17-5, the Parties stipulate and agree that any liability resulting from the State of Indiana's failure to make prompt payment shall be based solely on the amount of

funding originating from the State of Indiana and shall not be based on funding from federal or other sources.

4.41 Progress Reports

The Contractor shall submit progress reports to the State upon request. The report shall be oral, unless the State, upon receipt of the oral report, should deem it necessary to have it in written form. The progress reports shall serve the purpose of assuring the State that work is progressing in line with the schedule, and that completion can be reasonably assured on the scheduled date.

4.42 Severability

The invalidity of any section, subsection, clause or provision of this Contract shall not affect the validity of the remaining sections, subsections, clauses or provisions of this Contract.

4.43 Substantial Performance

This Contract shall be deemed to be substantially performed only when fully performed according to its terms and conditions and any modification thereof.

4.44 Successors and Assignees

The Contractor binds its successors, executors, administrators, and assignees to all covenants of this Contract. Except as above set forth, the Contractor shall not assign, sublet or transfer interest in this Contract without the prior written consent of the State of Indiana.

4.45 Taxes

The State of Indiana is exempt from state, federal, and local taxes. The State will not be responsible for any taxes levied on the Contractor as a result of this Contract.

4.46 Termination for Convenience

This Contract may be terminated, in whole or in part, by the State whenever, for any reason, the State determines that such termination is in the best interest of the State. Termination of services shall be effected by delivery to the Contractor of a Termination Notice at least thirty days prior to the termination effective date, specifying the extent to which performance of services under such termination becomes effective. The Contractor shall be compensated for services properly rendered prior to the effective date of termination. The State will not be liable for services performed after the effective date of termination. The Contractor shall be compensated for services herein provided but in no case shall total payment made to the Contractor exceed the original contract price or shall

any price increase be allowed on individual line items if canceled only in part prior to the original termination date.

4.47 Termination for Default

4.47.1 With the provision of thirty (30) days notice to the Contractor, the State may terminate this Contract in whole or in part, if the Contractor **fails to**:

- Correct or cure any breach of this Contract;
- Deliver the supplies or perform the services within the time specified in this Contract or any extension;
- Make progress so as to endanger performance of this Contract; or
- Perform any of the other provisions of this Contract.

4.47.2 If the State terminates all or part of this Contract for Default, the Contractor shall be liable for actual damages as determined by the State, to include costs of procuring, testing and implementing a replacement vendor or vendors. The Contractor shall cooperate with the State and State-designated replacement vendor or vendors to facilitate the transition of services on a schedule and plan set by the State. The State reserves the right to withhold the amount of damages from ongoing service payments to the Contractor.

4.47.3 The State shall pay the contract price for completed supplies delivered and services accepted. The Contractor and the State shall agree on the amount of payment for manufacturing materials delivered and accepted and for the protection and preservation of the property. Failure to agree will be a dispute under the Disputes clause. The State may withhold from these amounts any sum the State determines to be necessary to protect the State against loss because of outstanding liens or claims of former lien holders.

4.47.4 The rights and remedies of the State in this clause are in addition to any other rights and remedies provided by law or equity or under this Contract.

4.48 Waiver of Rights

No right conferred on either party under this Contract shall be deemed waived and no breach of this Contract excused, unless such waiver or excuse is in writing and signed by the party claimed to have waived such right.

Failure of the State to enforce at any time any provision of this Contract shall not be construed as a waiver thereof. The remedies herein reserved shall be cumulative and additional to any other remedies in law or equity.

4.49 Work Standards

The Contractor shall execute its responsibilities by following and applying at all times the highest professional and technical guidelines and standards. If the State becomes dissatisfied with the work product of or

the working relationship with those individuals assigned to work on this Contract, the State may request in writing the replacement of any or all such individuals, and Contractor shall grant such request.

4.50 State Boilerplate Affirmation Clause

The Contractor will be required, subject to the penalties of perjury that they have not altered, modified or changed the State's Boilerplate contract clauses or the Office's additionally required clauses except for those that have been reserved and except for those identified at the time of contract execution.

4.51 Assurance of Compliance with Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990 and Title IX of the Education Amendments of 1972

The Contractor agrees that it, and all of its subcontractors and providers, will comply with the following:

4.51.1 Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Contractor receives Federal financial assistance under this Contract.

4.51.2 Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Contractor receives Federal financial assistance under this Contract.

4.51.3 The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Contractor receives Federal financial assistance under this Contract.

4.51.4 The Americans with Disabilities Act of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 C.F.R. 35.101 et seq.), to the end that in accordance with the Act and Regulation, no person in the United States with a disability shall, on the basis of the disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which the Contractor receives Federal financial assistance under this Contract.

4.51.5 Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681, 1683, and 1685-1686), and all requirements imposed by or pursuant to regulation, to the end that, in accordance with the Amendments, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which the Contractor receives Federal financial assistance under this Contract.

4.51.6 The Contractor agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Contractor, its successors, transferees and assignees for the period during which such assistance is provided. The Contractor further recognizes that the United States shall have the right to seek judicial enforcement of this assurance.

4.52 Conveyance of Documents and Continuation of Existing Activity

Should the Contract for whatever reason, (i.e. completion of a contract with no renewal, or termination of service by either party), be discontinued and the activities as provided for in the Contract for services cease, the Contractor and any subcontractors employed by the terminating Contractor in the performance of the duties of the Contract shall promptly convey to the State of Indiana, copies of all contractor working papers, data collection forms, reports, charts, programs, cost records and all other material related to work performed on this Contract.

The Contractor and the Office shall convene immediately upon notification of termination or non-renewal of the Contract to determine what work shall be suspended, what work shall be completed, and the time frame for completion and conveyance. The Office will then provide the Contractor with a written schedule of the completion and conveyance activities associated with termination. Documents/materials associated with suspended activities shall be conveyed by the Contractor to the State of Indiana upon five days' notice from the State of Indiana. Upon completion of those remaining activities noted on the written schedule, the Contractor shall also convey all documents and materials to the State of Indiana upon five days' notice from the State of Indiana.

4.53 Environmental Standards

If the contract amount set forth in this Contract is in excess of $100,000, the Contractor shall comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 U.S.C. § 7606), section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. Part 32), which prohibit the use under non-exempt Federal contracts of facilities included on the EPA List of Violating Facilities. The Contractor shall report any violations of this paragraph to the State of Indiana and to the United States Environmental Protection Agency Assistant Administrator for Enforcement.

4.54 Lobbying Activities

Pursuant to 31 U.S.C. § 1352, and any regulations promulgated there under, the Contractor hereby assures and certifies that no federally appropriated funds have been paid, or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress, in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative contract. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Contract, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions.

4.55 HIPAA Business Associate Agreement

OMPP is a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA). The Contractor resulting from this RFP acknowledges they are a Business Associate of OMPP under HIPAA, and that their services involve the use of Protected Health Information (PHI). OMPP recognizes the requirements of HIPAA and intends to comply with all HIPAA requirements and requires the Contractor, as a Business Associate, to comply with all HIPAA requirements. The following specific HIPAA requirements are incorporated into the contract to protect the confidentiality and security of patients' PHI, as set forth in, but not limited to, Title 45, Sections 164.502(e), 164.504(e), 164.308(b), and 164.314(a - b) (as may apply) of the Code of Federal Regulations (CFR) and contained in this Agreement.

4.55.1 Definitions specific to this section

- Business Associate. "Business Associate" shall mean the Contractor resulting from this procurement.
- Access. "Access" means the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource. (This definition does not apply to paragraph 1 (e), below.)
- Administrative safeguards. "Administrative safeguards" are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information.
- Authentication. "Authentication" means the corroboration that a person is the one claimed.
- Availability. "Availability" means the property that data or information is accessible and useable upon demand by an authorized person.
- Covered Entity. "Covered Entity" shall mean the State of Indiana Family and Social Services Agency and Office of Medicaid Policy and Planning, as the State-designated operators of the Indiana Health Coverage Programs (IHCP).
- Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- Confidentiality. "Confidentiality" means the property that data or information is not made available or disclosed to unauthorized persons or processes.
- Encryption. "Encryption" means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key.
- Facility. "Facility" means the physical premises and the interior and exterior of a building(s).
- Information system. "Information system" means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.
- Integrity. "Integrity" means the property that data or information have not been altered or destroyed in an unauthorized manner.

- Malicious software. "Malicious software" means software, for example, a virus, designed to damage or disrupt a system.
- Password. "Password" means confidential authentication information composed of a string of characters.
- Physical safeguards. "Physical safeguards" are physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.
- Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
- Protected Health Information. "Protected Health Information" and "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
- Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee. § 164.304 Definitions.
- Security incident. "Security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- Security or Security measures. "Security" or "Security measures" that encompass all of the administrative, physical, and technical safeguards in an information system.
- Security Rule. "Security Rule" shall mean the Security Standards for the protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.
- Technical Safeguards. "Technical safeguards" means the technology and the policy and procedures for its use that protect electronic protected health information and control access to it.
- User. "User" means a person or entity with authorized access.
- Workstation. "Workstation" means an electronic computing device, for example, a laptop or desktop computer, or any other device that performs similar functions, and electronic media stored in its immediate environment.

- All other terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the HIPAA Privacy Rule.

4.55.2 Obligations and Activities of Business Associate

4.55.2.1 Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.

4.55.2.2 Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.

4.55.2.3 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

4.55.2.4 Business Associate agrees to promptly report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware. This includes any requests for inspection, copying or amendment of such information and including any security incident involving PHI.

4.55.2.5 Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

4.55.2.6 If Business Associate has Protected Health Information in a Designated Record Set: Business Associate agrees to provide access, at the request of Covered Entity during regular business hours, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual within 10 business days of receiving the request.

4.55.2.7 Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, upon

request of either, for purposes of determining Covered Entity's compliance with the Privacy Rule.

4.55.2.8 Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

4.55.2.9 Business Associate agrees to provide to Covered Entity or an Individual, upon request, information collected in accordance with Paragraphs g and h above, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

4.55.2.10 Business Associate agrees to comply with all Security Rule standards and specifically as required by 45 CFR § 164.308(b). Business Associate must also satisfy the requirements of 45 CFR § 164.314 paragraph (a)(2)(i) or (a)(2)(ii), as applicable.

4.55.2.11 Business Associate specifically agrees to use security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information in electronic or any other form, that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

4.55.2.12 Business Associate agrees to implement security measures to secure passwords used to access electronic protected health information that it accesses, maintains, or transmits as part of this contract or agreement protected from malicious software and other man-made and natural vulnerabilities to assure the availability, integrity, and confidentiality of such information.

4.55.2.13 Business Associate agrees to implement security measures to safeguard electronic protected health information that it accesses, maintains, or transmits as part of this contract or agreement from malicious software and other man-made and natural vulnerabilities to assure the availability, integrity, and confidentiality of such information

4.55.3 Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement or any related agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in any and all contracts with Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

4.55.4 Specific Use and Disclosure Provisions

4.55.4.1 Except as otherwise limited in this Agreement or any related agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.55.4.2 Except as otherwise limited in this Agreement or any related agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

4.55.4.3 Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B), only when specifically authorized by Covered Entity.

4.55.4.4 Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 CFR § 164.502(j)(1).

4.55.5 Obligations of Covered Entity

4.55.5.1 Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information, by providing a copy of the most current Notice of Privacy Practices (NPP) to Business Associate as Attachment I to this Agreement. Future Notices and/or modifications to the NPP shall be posted on Covered Entity's website.

4.55.5.2 Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

4.55.5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance

with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.55.6 Permissible Requests by Covered Entity

Except for data aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

4.55.7 Effective Date and Termination

4.55.7.1 The Parties hereby agree this agreement replaces and supersedes any prior Business Associate Agreement entered into between Covered Entity and Business Associate.

4.55.7.2 These Business Associate provisions, with the exception of the electronic security provisions, shall be effective upon the later of April 14, 2003, or the effective date of the earliest contract entered into with Covered Entity that involves the use of PHI. The electronic security provisions shall be effective the later of April 21, 2005 or the effective date of the earliest contract entered into with Covered Entity that involves the use of PHI.

4.55.8 Termination for Cause.

4.55.8.1 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

4.55.8.2 Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

4.55.8.3 Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

4.55.8.4 If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

4.55.9 Effect of Termination.

Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information. In

the event that Business Associate or Covered Entity determines that returning the Protected Health Information is infeasible, notification of the conditions that make return of Protected Health Information infeasible shall be provided to the other party. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information, for a minimum of six years and so long as Business Associate maintains such Protected Health Information, but no less than six (6) years after contract termination

4.55.10 Miscellaneous

4.55.10.1 Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

4.55.10.2 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

4.55.10.3 Survival. The respective rights and obligations of Business Associate of this Agreement shall survive the termination of this Agreement.

5 Scope of Work

5.1 General Operations Requirements

5.1.1 Overview and Business Objective

The objective for the General Operations Requirements function is to ensure that contract responsibilities not directly tied to a specific business function, that apply to multiple business functions, or that are system-related are performed to the State's satisfaction. The Contractor is responsible for executing all cycles contained in Indiana*AIM* and must therefore provide system support for functions performed by other contractors.

5.1.2 System Support

The system support features of Indiana*AIM* are described in subsequent subsections contained within this operations scope of work.

The Contractor is required to maintain and support all computers, disk arrays, computer peripherals, networks, communication devices, operating systems, databases, interfaces, translators, computer-technology integration (CTI) products, development and compiling software, web development software, hardware and network monitoring tools and devices, security software and devices, disaster recovery sites and tools, secure data storage methods, purchased or licensed software, systems, subsystems, components, and all other elements required to meet or support the requirements of this RFP.

Specifically, the Contractor must maintain and support the Indiana*AIM* system itself, Business Objects, Unix, Sun/Solaris, the Decision Support System, First Steps systems (SPOE, CCG, CRO, Matrix web site), imaging software (Captiva is the current solution), translator software, call-center management (CTI) software, Microsoft Office products, Microsoft dot.NET development suite, PowerBuilder, C++ and C# programming suites, and all other development and implementation tools necessary for the successful deployment, operation and maintenance of systems supporting this contract.

All references to support or maintenance of Indiana*AIM* shall include the requirement of the Contractor to support these and any other components used to meet or support contract requirements.

5.1.3 Office Location and Facilities

5.1.3.1 The Contractor shall maintain its principal office to interface with State staff and manage the administration of the contract in Indianapolis, Indiana, within five miles of the State capitol

building. The Contractor shall submit a plan as part of their proposal, subject to State approval, to maximize the beneficial employment impact to Indiana residents living outside the Indianapolis area, without degrading the necessary communication with State oversight staff working in Indianapolis. Evaluation preference will be given for a plan that meets this objective, including the possible location of functions such as mailrooms, call centers, data centers, publication and print centers, ID card production and similar functions within Indiana, but outside the Indianapolis area. Programmers and systems analysts that must work with State should be located at the principal office in Indianapolis.

The Contractor is responsible for all costs and expenses associated with any office or data center used to meet requirements under this contract. The following functions must be performed in Indiana, except as expressly approved by the State, at the sole option of the State, in writing:

- Project and account management
- Mailroom functions
- Paper claims receipt and processing
- Imaging
- Telephone call center operations
- Systems modification and maintenance
- Printing
- Check production and EFT creation
- Requirements Analysis
- Programming
- Preparation of training materials
- Preparation of publications
- Website modifications
- Coordination of State and other contractor operations
- All of services in which staff or equipment is billed under the Contract.

5.1.3.2 The Contractor shall provide office space and furniture at its principal office at no additional charge to the State for up to four (4) State staff members designated by the State, allocating 100 square feet for each staff member. The Contractor shall furnish the offices with desks, chairs, file cabinets and other appropriate office furniture as approved by the State, with costs not to exceed $1,250 per office. The Contractor shall provide wiring for telephone and computer connections. The offices shall be separately secured with locks or electronic security keypads as approved by the State. State staff members shall

have access to their space at any time, day or night, including holidays and weekends. The Contractor shall provide a laser printer, fax machine, and copy machine in an area accessible by state staff only.

5.1.3.3 The Contractor shall provide ten reserved free parking spaces for State employees and contractors. These parking spaces shall be in the front row of parking spaces or structure closest to the building.

5.1.3.4 The Contractor shall provide full access to all of its facilities and hardware supporting services covered under this contract to State contract monitoring staff, designated by the State, without notice and without escort, for the purpose of monitoring all Fiscal Agent activities. The Contractor shall provide notice to the State for any meeting to be held at the Contractor's principal office to discuss Indiana Medicaid business; the State has the option to attend any such meeting, at the discretion of the State.

5.1.3.5 Except as specifically itemized in this RFP or expressly approved in writing by the State, the Contractor shall provide all hardware, Commercial-Off-The-Shelf (COTS) software, licenses, communications devices, routers, firewalls, internal wiring and circuits, furniture, telephones, telephone switching equipment, computers, printers, office supplies, equipment, and all other materials necessary to fulfill the requirements of this contract. The Contractor is similarly responsible for all periodic operating expenses, including utilities, telephone charges, Internet and communications circuit charges, and all other expenses necessary to fulfill the requirements of this contract. The Contractor is required to supply and pay for any required licenses for any product designated to be used by State staff or other contractor staff to meet requirements of this contract.

5.1.4 Staff Requirements and Qualifications

The Contractor must provide all the staff necessary to meet the requirements in this RFP at the Contractors expense. Except as specifically provided in the Contract, the State will not pay for staff, staff expenses, staff overhead, staff travel, or any related staff expenses

5.1.4.1 Staffing Management

For all Projects, the Contractor must create a Staffing Management Plan, including organizational charts with defined responsibilities and contact information. Resources must be

allocated by name or by type to the WBS. The Respondent must provide month-by-month minimum commitment staffing levels during the implementation and operational phase of the Contract as described in Section 3.4.1.5. During Project execution, the Contractor must provide appropriate training and management supervision to all staff.

5.1.4.2 Staff Categories

The Contractor must provide staff in the following three categories:

1. Key Staff. These are itemized in the RFP as Key Positions, Key Staff or Key Staff Positions. The Respondent must provide resumes for this staff as discussed in Section 3.4.1.6. This staff is subject to State approval. The State may require the removal and replacement of any Key Staff at any time, with or without cause.

   Replacement of any key personnel, including those who have terminated employment, shall be with personnel of equal or greater ability and qualifications and will be subject to approval by the State. Upon notification, the Contractor must remove the Key Staff member within 14 calendar days, and must replace the Key Staff member with a person acceptable to the State within 30 calendar days.

   Key personnel assigned to the Indiana account are not permitted to manage, oversee, or participate in other projects, contracts, etc. Any redirection of personnel (such as, assisting another client), either temporarily or permanently, shall require prior approval of the State.

2. Categorized Staff. These are itemized in the RFP. The Contractor must supply the number of staff in the categories and for the purposes specified in the RFP. All staff in these categories must meet the minimum qualification specified in the RFP. Failure to maintain the required staffing level may result in monetary penalties against the Contractor.
3. Management, Maintenance, Operations and Support Staff. The Contractor must supply sufficient staff at the Contractors expense to manage all aspects of Indiana*AIM* and Fiscal Agent services; to Maintain Indiana*AIM* and all associated systems, communications, networks and software; to Operate Indiana*AIM* and provide all the Fiscal Agent and other

services required by this contract; and to support administratively and technically all contractors work in fulfillment of this contract

5.1.4.3 Key Personnel

The following are Key Staff Positions:

1. Project Manager
2. Deputy Project Manager
3. Operations Manager
4. Chief Financial Officer
5. Provider Relations Manager
6. Systems Director
7. Claims Processing Manager
8. Managed Care Manager
9. TPL Manager
10. Provider Enrollment Supervisor
11. Publications Manager
12. Pharmacy Benefit Manager
13. EPST Coordinator
14. Managed Care Administrator
15. LTC Manager
16. MAR Report Analyst
17. Data and Report Analyst
18. Privacy Officer
19. Security Officer
20. Quality Assurance Manager
21. Pharmacist Reviewer

5.1.4.4 Categorized Staff

The following are Categorized Staff Positions with the minimum staffing level requirements:

1. System Engineer (minimum of 1 FTE)
2. Database Administrator (minimum of 2 FTEs)
3. Business Analyst (minimum of 2 FTEs)
4. Systems Architect (1 FTE)
5. UNIX Systems Administrator (minimum of 2 FTEs)
6. LAN/WAN Administrators (minimum of 2 FTEs)
7. Quality Assurance Analysts (minimum of 5 FTEs)

5.1.4.5 Maintenance, Operations and Support Staff

The following are Maintenance, Operations and Support Staff Positions:

1. Provider Communications/Relations Staff
2. Off site Provider Field Consultants
3. Eligibility Technical Assistant

4. Central Librarian
5. Waiver Specialist
6. On-Site Facility Reviewers
7. Reconsiderations Nurse
8. System Operators and Monitors
9. Trainers
10. Staff Support for 24/7 Data Center
11. Reference File Business Associates
12. Senior Reporting Specialist
13. Programmers
14. Business Analysts
15. Testing Staff
16. Documentation Specialists

5.1.4.6 Key Staff Definition and Qualifications

Staff Position	Staff Qualifications
Project Manager	Minimum of five (5) years of Medicaid related system design and management experience including the management of one (1) MMIS/DSS systems design and development project similar in size and scope to this project. A bachelor's degree in computer science or a related field is also required. Preference to experience in Indiana Medicaid.
Deputy Project Manager	Minimum of three (3) years of Medicaid related system design and management experience including participation in one (1) MMIS/DSS systems design and development project similar in size and scope to this project. A bachelor's degree in computer science or a related field is also required. PMP or equivalent certification. Preference to experience in Indiana Medicaid.
Operations Manager	Minimum of four (4) years of MMIS operation experience as manager. A bachelor's degree in computer science or a related field is also required. Preference to experience in Indiana Medicaid.
Chief Financial Officer	Degree in Finance or Accounting, active and licensed Certified Public Accountant (CPA) or Certified Internal Auditor (CIA) with five (5) years of banking, accounting or auditing experience in a large-scale operation.

Staff Position	Staff Qualifications
Provider Relations Manager	A bachelor's degree and minimum of four (4) years experience managing provider relations functions for a Medicaid program, other government health care program, or health care related organization. Experience and/or training in recipient eligibility management and significant experience in a call center operation are also required. Preference to experience in Indiana Medicaid.
Systems Director	Minimum of five (5) years of Medicaid related system design and management experience including the management of one (1) MMIS/DSS systems design and development project similar in size and scope to this project. A bachelor's degree in computer science or a related field is also required.
Claims Processing Manager	A bachelor's degree and minimum of four (4) years experience managing claims processing operations and personnel for a government or private sector health care payor, including a minimum of two (2) years MMIS experience. Previous relevant experience in a health care or health care payer environment, including familiarity with health care claim billing procedures and procedural coding systems, HIPAA X12 transactions, claim forms, medical privacy and security issues.
Managed Care Manager	A bachelor's degree and minimum of two (2) years Medicaid or managed care administration experience.
Third Party Liability Manager	A bachelor's degree and minimum of two (2) years TPL experience.

Staff Position	Staff Qualifications
Provider Enrollment Supervisor	An Associate's degree or equivalent. Previous relevant experience in a health care or health care payer environment, including familiarity with provider enrollment and credentialing, health care claim billing procedures and procedural coding systems, HIPAA X12 transactions, claim forms, medical privacy and security issues.
Publications Manager	An Associate's degree or equivalent. A minimum of five years experience in English, technical writing, communications, or a related field. Requires submission of written documents utilizing technical writing.
Pharmacy Benefit Manager	An bachelor's degree or equivalent. AT least three (3) years experience in Pharmacy Benefits Management.
EPST Coordinator	An Associate's degree and minimum of two (2) years relevant experience.
MANAGED CARE Administrator	A bachelor's degree and minimum of two (2) years relevant experience.
Long Term Care Manager	A registered nurse and minimum of two (2) years relevant experience.
Management and Reporting (MAR) Analyst	A bachelor's degree and minimum of two (2) years experience in analyzing MAR reports.
Data and Report Analyst	A bachelor's degree and minimum of two (2) years in health care data analysis.

Staff Position	Staff Qualifications
Privacy Officer	Certification as an Registered Health Information Administrator (RHIA) or Registered Health Information Technician (RHIT) or other HIPAA Privacy Credentialing body and/or education and experience relative to the size and scope of Indiana*AIM*.
Security Officer	A bachelor's degree required and graduate degree preferred with a minimum of two (2) years in providing information security to a complex entity and experience in health industry compliance.
Quality Assurance Manager	A bachelor's degree with at least three (3) courses in statistics and/or quality assurance and a minimum of three (3) years progressive experience in the quality assurance function of a large scale claims processing organization or have at least five (5) years progressive experience in the quality assurance function of a large scale claims processing organization.
Database Administrator	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years of database experience for MMIS similar in size and scope to this project.
Business Analyst	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years of database experience for MMIS similar in size and scope to this project.
Systems Architect	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years of system design experience for MMIS similar in size and scope to this project.

Staff Position	Staff Qualifications
UNIX Systems Administrator	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years of operating UNIX for MMIS similar in size and scope to this project.
LAN/WAN Administrators	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience with local and wide-area networks for MMIS similar in size and scope to this project.
Quality Assurance Analysts	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience in conducting and operating tests for MMIS similar in size and scope to this project.
Provider Communications/Relations Staff	An Associate's degree or equivalent. Experience in English, technical writing, communications, or a related field.
Off site Provider Field Consultants	An Associate's degree or equivalent with a minimum of three (3) years experience assisting with provider relations for a Medicaid program, other government health care program, or health care related organization.
Eligibility Technical Assistant	An Associate's degree or equivalent with a minimum of three (3) years experience determining recipient eligibility for a Medicaid program, other government health care program, or health care related organization.
Central Librarian	A bachelor's degree and minimum of two (2) years in health care data documentation.

Staff Position	Staff Qualifications
Waiver Specialist On-Site	A bachelor's degree and minimum of two (2) years experience in resolving provider issues for a Medicaid program, other government health care program, or health care related organization.
Facility Reviewers	A registered nurse or social worker with a minimum of two (2) years experience in review of facilities such as hospice and PASRR function for a Medicaid program, other government health care program, or health care related organization.
Reconsiderations Nurse	A registered nursed with a minimum of two (2) years experience in representing the State at appeal hearings and review determination of team audits.
System Operators and Monitors	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience with operations for MMIS similar in size and scope to this project.
Trainers	A bachelor's degree with experience in a minimum of three (3) years experience with training for a Medicaid program, other government health care program, or health care related organization.
Staff Support for 24/7 Data Center	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience with a call center operation for a Medicaid program, other government health care program, or health care related organization.
Reference File Business Associates	An Associate's degree or equivalent with experience in a minimum of two (2) years experience for a Medicaid program, other government health care program, or health care related organization.

Staff Position	Staff Qualifications
Senior Reporting Specialist	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience with reporting analysis for MMIS similar in size and scope to this project.
System Engineer	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience for MMIS similar in size and scope to this project.
Pharmacist Reviewer	A registered pharmacist with experience in a minimum of three (3) years experience in establishing and conducting a pharmacy quality assurance review.
Programmers	A bachelor's degree in Computer Science or a related field with experience in a minimum of three (3) years experience with developing and coding for MMIS similar in size and scope to this project.
Testing Staff	A bachelor's degree with at lease two (2) years experience in conducting and operating acceptance tests for a MMIS similar in size and scope to this project.
Documentation Specialists	A bachelor's degree with at lease two (2) years experience in preparing and organizing documentation for a Medicaid program, other government health care program, or health care related organization...

5.1.5 State Responsibilities

5.1.5.1 Initiate or approve report changes, additions, deletions, and other modifications to Indiana*AIM* functions.

5.1.5.2 Monitor the Contractor's database/file maintenance process to ensure integrity of the data sets and database tables/files used to support the IHCP.

5.1.5.3 Review and approve newsletters, bulletins, etc., prepared by the Contractor.

5.1.5.4 Review and approve (or require modifications to) Indiana*AIM* system documentation and user documentation updates.

5.1.5.5 Review and approve Indiana*AIM* software updates and hardware upgrades.

5.1.5.6 Initiate or review and approve Contractor suggested updates to the report distribution list.

5.1.6 Contractor Responsibilities

Hours of Operation

5.1.6.1 Provide online access for inquiry to Indiana*AIM* and all its applications for authorized users from at least 6:00 a.m. through 6:00 p.m. Indianapolis time, Monday through Sunday, excluding State holidays.

5.1.6.2 Provide access for online updates to Indiana*AIM* and all its applications for authorized users from at least 7:30 a.m. through 6:00 p.m., Monday through Sunday, excluding State holidays.

5.1.6.3 Ensure that average response time for inquiry and update transactions complies with the standards set forth in Section 4.

5.1.6.4 Provide access to a communication server to facilitate access to Indiana*AIM* for all entities with the appropriate security clearance.

5.1.6.5 Provide a secure means of accessing Contractor-supported systems through any Internet connection, using approved connections to the State's network, Virtual Private Networks (VPNs), and secure remote access services as approved or directed by the State.

5.1.6.6 During the hours of 8 a.m. to 5 p.m. Indianapolis time, the Contractor must provide a means for the State to contact Contractor management staff for urgent issues with a maximum response time of 30 minutes to acknowledge receipt of an issue and discuss the effort to research and resolve the issue.

Reporting

5.1.6.7 Modify Indiana*AIM* system-generated reports to meet the changing information needs of the Indiana medical assistance program(s); respond to requests for changes made by the State

or other contractors; and ensure compliance with changes in, federal, state, or department regulations, procedures, or policies.

5.1.6.8 Produce and deliver all Indiana*AIM* reports and other outputs within the time frames specified in this RFP or as otherwise directed by the State and according to the format, input parameters, content, frequency, media (including hard copy, micromedia, electronic media, CRLD, data transfer file, tape, CD-ROM, DVD-ROM, flash disk, and any other media selected by the state), and number of copies required by the State. Deliver to State staff, contractors, or other entities as directed by the State.

5.1.6.9 Generate hard copy reports on 8-1/2" x 11" paper on a laser printer, with the capability to print single- or double-sided, in either portrait or landscape orientation.

5.1.6.10 Maintain and update, subject to State approval, the Indiana*AIM* report distribution lists.

5.1.6.11 Maintain and update CRLD (Computer Reports to Laser Disk). CRLD provides on line access to system-generated reports.

5.1.6.12 Produce all required Federal and State reports, including financial reports.

5.1.6.13 Provide training and documentation for all State personnel and, where appropriate, other contractors' personnel, on interpreting and using Indiana*AIM* report data and use of Indiana*AIM* inquiry and update functions. Individuals who may participate in training include the OMPP staff and individuals from other departments, agencies, and contractors.

5.1.6.14 Ensure that all reports are accurate and delivered in the timeframes specified by the State.

Training

5.1.6.15 Conduct an assessment of State personnel and other contractors' personnel at least annually and at the direction of the State to determine their training needs as it relates to their use of, and interface with, Indiana*AIM* functionality, procedures, processes, data, and reports. Present the assessment for State review and approval. Modify the report at the direction of the State.

5.1.6.16 Provide training in the use of Indiana*AIM* and other systems used to support the business function to State personnel and other contractors' personnel on a frequency to meet the needs

of the annual training assessment specified above or as directed by the State.

Documentation

5.1.6.17 Maintain up-to-date Indiana*AIM* user documentation and system documentation for all components of the system and all systems used by the Contractor to meet the requirements of this RFP as changes are made. Documentation must be accurate, clearly written, and consistent (for example, definitions, process descriptions, etc.).

5.1.6.18 Provide the State with updates to the Code Tables Manual within ten (10) business days of executing a change to a table included in the Code Tables Manual.

5.1.6.19 Provide the State with updates to the Claims Resolution Manual when changes are made to edit/audit criteria or claims resolution criteria, when new edits or audits are added, etc. Updates shall be provided within ten (10) business days of the effective date of the change.

5.1.6.20 Contractor shall mail any additional notices not specifically addressed in this statement of work to entities as specified by the State. The Contractor shall propose a cost per page for additional notices in the respective proposals. Place in pricing area as well.

Quality Management

5.1.6.21 The Contractor shall perform ongoing assessments of the quality of its operational activities. Activities performed shall include, at a minimum, the following:

- Review monthly samples of both hard copy and EMC-submitted IHCP claims to evaluate system integrity through accuracy of claims payment and recipient eligibility for dates of service.
- Evaluate system edits and audits for posting accuracy.
- Review file updates to ensure timeliness and accuracy (for example, HCPCS, ICD-9 procedure and diagnosis updates, etc).
- Analyze reasons for system downtime.
- Review and analyze provider enrollment and provider relations activities for accuracy and completeness.

5.1.6.22 The Contractor shall utilize the Capability Maturity Model Integration (CMMI) as developed by the Software Engineering Institute (SEI) of Carnegie-Mellon University as the standard

for the quality of the information systems and data processing organization component of the fiscal agent operations, or such other nationally recognized method as may be approved by the State. The Contractor shall report on progress in implementing the procedures that define the key process areas. If the Contractor elects to perform an independent certification, the certification level shall be reported to the OMPP.

5.1.6.23 The Contractor shall establish an independent quality management unit (IQMU) with a quality manager and five quality assurance analysts. The sole purpose of this unit shall be to assist the State in gathering information to assist in the monitoring of the performance and quality of performance of the work by the Contractor.

5.1.6.24 Candidates for the quality manager must meet the minimum requirements for a quality manager position under state employment.

5.1.6.25 Candidates for the quality assurance analysts must meet the minimum requirements for the quality assurance analyst position under state employment.

5.1.6.26 The Contractor shall ensure that personnel appointed to the IQMU are protected against reprisal for information reported to the State.

5.1.6.27 The IQMU staff shall report directly to the State and take all direction from the State.

5.1.6.28 The State may at its sole option choose to remove this responsibility from the Contractor.

5.1.6.29 If the state determines at its sole option to cross-walk the positions and / or people from this unit, the Contractor shall continue to provide all the workspace, parking, facilities, hardware, software, and other materials necessary to perform these functions. The Contractor must provide a minimum of a 100 square foot office and five 64 square foot work spaces for the IQMU.

5.1.6.30 The Contractor shall provide separate monthly pricing for the positions comprising the IQMU in the cost proposal. In the event that the state chooses to remove this responsibility from the Contractor, the contract resulting from this RFP shall be reduced by the monthly price multiplied by the number of months remaining in the contract.

5.1.6.31 For requirements without a specific quality rate identified, the Contractor shall perform all work 95% defect free.

5.1.6.32 Provide a monthly status report as defined by the State documenting the performance by the vendor of contract requirements. Include supporting documentation with the monthly report as required by the state to validate the monitoring of the performance.

System Security

5.1.6.33 Maintain the security features of Indiana*AIM* to ensure the system is protected against unauthorized access according to state and federal guidelines.

5.1.6.34 Ensure that Indiana*AIM* operations are in accordance with both state and federal regulations and guidelines related to security, confidentiality, and auditing.

5.1.6.35 Protect transmission lines and communications services and linkages between Indiana*AIM* and the State local area network (LAN) and Indiana*AIM* and the processing hardware from unauthorized access.

5.1.6.36 Maintain unique log-on IDs and security profiles for users authorized by the State, including other contractors, to have access to Indiana*AIM*.

5.1.6.37 Maintain restriction information for each application, function, and window to specific log-on IDs as part of the security profile.

5.1.6.38 Work with the State and the other contractors to identify and define 1) the windows that must be accessed by each contractors to support the requirements presented in the RFP and 2) the appropriate mode (inquiry, update, add) allowed for the accessed windows.

Hard-Copy Claim Retention

5.1.6.39 The Contractor shall ensure that all original hard-copy claims are maintained and retrievable for a retention period defined by the State. The State will review the Contractor's plan to assure accurate recording and maintenance of images, and will determine the retention schedule at the sole discretion of the State based on that review. The Contractor is responsible for the destruction of all hard-copy claims and claim-related material following the Contractor's State-approved document disposal plan.

Information Retrieval

5.1.6.40 Extract data from archived claims history to support the Estate Recovery process.

Third Party Liability

5.1.6.41 Receive and process daily updates of TPL information from the State's eligibility systems.

5.1.6.42 Provide updates of TPL information on a daily basis to the State's eligibility systems.

5.1.6.43 Generate and mail TPL notices, questionnaires, and retro billing invoices within three business days of the end of the month.

5.1.6.44 Produce claim facsimiles (hard copy or electronic) to bill carriers when retroactive TPL has been identified or for pay-and-chase claims, and mail them out with appropriate cover letter. Produce claim facsimiles at the State's request or as otherwise required to support TPL activities.

5.1.6.45 Execute and maintain the existing data matches supported by Indiana*AIM* and current sub-contractor systems.

5.1.6.46 Transfer deposits made as a result of collections to the Contractor's bank account nightly and report to the State the total dollars transferred. The Contractor shall also report the dollars that represent TPL collections as well as the dollars for non-dispositioned checks. Quarterly review and verify that deposits made in the reporting quarter balance correctly to information contained on the CMS-64.

5.1.6.47 Complete and submit the CMS-64 9R section of the CMS-64 report and provide information regarding TPL that is not available from the Indiana*AIM* reports (for example, checks deposited but not yet dispositioned). This information shall be submitted to the Non-Core Contractors within five business days of the end of the quarter.

5.1.6.48 Meet with the State and contractors designated by the State on a periodic basis to review and prioritize ad hoc report and data extract requests.

5.1.6.49 Develop and implement State-approved processes to fund refunds processed by the Contractor.

5.1.6.50 Perform TPL reviews to ensure the IHCP is the payor of last resort.

5.1.6.51 Work discrepancies between ICES and other State eligibility systems and Indiana*AIM* within three business days. Add carrier updates within five business days or as approved by the state.

Coordination Activities - Prior Authorization

5.1.6.52 Generate and mail approved, denied, and suspended prior authorization (PA) notices to requesting providers and recipients within one business day of receiving the status decision from the State or State-designated Contractor. The Contractor shall prepare and submit a monthly report to the State documenting how the standard is or is not being met.

5.1.6.53 Make PA forms available on the IHCP Web site as specified by the State within five (5) days of the State's request.

5.1.6.54 Make PA bulletins available on the IHCP Web site as necessary. The State or State designated Contractor is responsible for preparing the content of the bulletins and forwarding it to the Contractor for production.

5.1.6.55 Provide the Medical Policy Contractor with necessary support (for example, gathering claims information) during the provider appeal process.

Coordination Activities - SUR

5.1.6.56 Provide technical assistance to the Medical Policy and Review Services Contractor as necessary to support changes to the SUR Control File. The Medical Policy Contractor is responsible for entering in the SUR Control File updates using Indiana*AIM*'s on-line windows.

5.1.6.57 Support and accept updates to the SUR file.

5.1.6.58 Make SUR quarterly bulletins available on the IHCP Web site within 30 calendar days after the end of a quarter and/or upon receipt of the bulletin information. The Medical Policy Contractor is responsible for preparing the content of the bulletins and forwarding them to the Contractor.

Additional General Requirements

5.1.6.59 Make Medical Policy information available on the IHCP Web site as specified by the State**.**

5.1.6.60 Maintain and utilize a National Provider Identifier (NPI) strategy and crosswalk to properly identify provider records, claims, electronic transactions, remittance advice information, and all other records in a uniform, efficient manner throughout the system.

5.1.6.61 Contract for an annual SAS-70 audit and such other audits as are appropriate to comply with federal laws and guidelines, such as the HIPAA Security Rule, at the Contractor's expense. Provide results of the audit within 30 calendar days of its

delivery to the Contractor, with a detailed response to include actions to be taken by the Contractor to effectively correct any negative findings. Take all necessary corrective measures and report on their completion within 90 calendar days of receipt of the audit findings or on a schedule agreed to by the state.

5.1.6.62 Utilize an Information Systems Development Methodology (ISDM) and Project Management Methodology (PMM). The methodology must be approved by the state. Maintain and deliver all artifacts, planning documents, project management documents, design materials, system documentation, work breakdown structures, activity duration estimates, activity sequencing documentation, critical path analysis, resource allocation, actual time and resource measures, and all other materials required by the ISDM and PMM on a schedule approved by the state. Maintain and deliver the materials for online reference and deliver in hard copy in formats dictated by the state. If the state mandates a configuration management system or change control system, the Contractor must conform. The Contractor shall provide staff to participate in the State's change control board including a maximum of three staff from the contractor, which will include state approval of the Contractor's staff who participate on the State's change control board.

5.1.6.63 Provide an annual business plan to the State by November one of each contract year.

5.1.6.64 Provide access and security levels to Contractor supported systems to the State and other contractors as specified by the State.

5.1.6.65 Provide data extracts, documentation, and any other deliverables specified in the Statement of Work to other entities as mandated by the State.

5.1.6.66 Changes to State and Federal law regarding the name, format, and / or framework of the programs and / or services provided under the Indiana Health Coverage Programs shall be considered included in this Statement of Work. The State shall pay for necessary system enhancements to support the changes.

5.1.6.67 The Contractor shall staff, maintain and operate a HIPAA Privacy Office, under the direction of the HIPAA Privacy Officer. The HIPAA Privacy Office shall create and maintain compliance plans, operating manuals, and HIPAA Privacy Policies and Procedures subject to State approval. All HIPAA Privacy Office operations shall conform to the State's HIPAA policies and procedures. The Contractor shall follow and

adhere to the approved HIPAA Privacy Policies and Procedures, and shall report on compliance and deviations from compliance as directed by the State.

5.1.6.68 The Contractor shall staff, maintain and operate a HIPAA Security Office, under the direction of the HIPAA Security Officer. The HIPAA Security Office shall create and maintain compliance plans, operating manuals, and HIPAA Security Policies and Procedures subject to State approval. All HIPAA Security Office operations shall conform to the State's HIPAA policies and procedures. The Contractor shall follow and adhere to the approved HIPAA Security Policies and Procedures, and shall report on compliance and deviations from compliance as directed by the State.

5.2 Provider Services

5.2.1.1 Overview and Business Objective

The Provider Services Unit (PSU) acts as a primary liaison between providers and the State. This function is crucial to ensuring that Indiana's provider community understands the responsibilities and rights associated with becoming an IHCP provider and with maintaining an active status. The primary purpose of the PSU is to provide technical assistance and training to enrolled and potential IHCP providers. Specifically, the PSU performs and coordinates the following types of functions:

- Provider enrollment, recruitment, and inquiry resolution
- Technical assistance and provider training for claims processing, prior authorization, etc.
- Electronic claims submission support
- Administrative reviews and appeals support and coordination
- Fraud, waste, and abuse prevention and referral
- Provider manual and bulletin development and maintenance
- Provider data table maintenance
- Customer satisfaction assessment
- Provider analysis

The Contractor shall approach this business function from a customer service perspective. Customers include OMPP staff; all IHCP providers, including managed care PMPs, managed care organizations, and waiver providers; and other contractors. The role of the Contractor is to provide courteous, efficient, and accurate responses to provider and State requests, inquiries, or complaints while coordinating with other functional areas when responding to provider inquiries, complaints, etc. The Contractor shall ensure that its staff is well trained to ensure that reliance on State staff for routine issues is minimal. The State should be contacted when

issues arise that potentially impact policy, and when providers communicate an intent to seek issue resolution by contacting State employees, officials, legislators, or the media. The Contractor is expected to be proactive in the area of provider services.

5.2.1.2 Provider Enrollment and Recruitment

The PSU is responsible for recruiting providers, guiding them through the enrollment process, ensuring that they are eligible, and approving or denying provider applications. Additionally, the unit is responsible for following OMPP-approved procedures for enrollment and both voluntary and involuntary disenrollment of providers, including PMPs participating in managed care. The Contractor must provide notification to providers that they are no longer eligible to participate in the IHCP program. The Contractor assists the State by enrolling and disenrolling managed care organizations (MCOs), and other entities as defined by the state while maintaining appropriate MCO information in Indiana*AIM*.

To appropriately manage the activities of the PSU, staff must be knowledgeable about licensure, certification requirements, and provider agreements. The PSU staff must also ensure that documentation and manuals are accurate and up to date in order to provide appropriate assistance.

To receive reimbursement under the Indiana medical assistance programs, a provider must be appropriately enrolled. A provider can be enrolled when all of the following conditions have been met:

- The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to applicable State or Federal law or otherwise authorized by the IFSSA or the ISDH.
- The provider has completed, signed, and returned a provider agreement and any other forms required by the State and has received an IHCP provider number.
- Out-of-state institutional or individual providers must be duly certified, licensed, registered, or authorized as required by the state in which the provider is located and must sign a provider agreement and receive an IHCP provider number before receiving any payment.
- Applicable provider recertification requirements as specified by the Indiana medical assistance programs must be satisfied.

When a provider is enrolled, the PSU is responsible for updating provider records and ensuring that provider recertification requirements are met in a timely fashion.

Under this contract, it is the State's expectation that the Contractor shall take a proactive and effective approach to the recruitment of providers and increasing the participation of those providers enrolled in the IHCP. As part of the development of the Contractor's Annual Business Plan, the Contractor shall meet with the State to discuss and identify the types of providers or geographic areas to be targeted for recruitment in the upcoming year. The Contractor is responsible for conducting research to identify non-participating providers, determining why the providers have ceased to participate in the IHCP, and developing and implementing strategies to increase participation and recruit new providers.

5.2.1.3 Technical Assistance and Training

Providing technical assistance and training to providers is a fundamental, ongoing responsibility of the PSU. The Contractor shall strive to resolve all provider issues as efficiently as possible so the provider does not resort to contacting the OMPP. Technical assistance activities primarily refer to researching and responding to provider inquiries in a timely fashion, either verbally or in writing. Providers may have questions about billing, the status of a particular claim or an adjustment, electronic claims submission, electronic funds transfer, member eligibility verification for dates of service not available via AVR, prior authorization requirements, TPL requirements, etc. If the PSU cannot provide an answer to the provider, the staff is expected to refer the provider to the appropriate resource or research the issue and respond accordingly. It is expected that responses to all inquiries will be professional, accurate, thorough, and timely.

To stay up to date on provider concerns, Contractor staff will be required to attend and participate in all provider association meetings.

The PSU also provides a variety of provider training opportunities. The current structure provides regional field consultants who educate the community leaders in their regions and develop and initiate training opportunities for the providers in their region. Field consultants conduct workshops and seminars ranging from training provider office staff on general

IHCP policies and procedures to customized topics requested by providers or provider groups.

The PSU is responsible for conducting training on waiver programs as needed to ensure that providers are well informed of waiver program opportunities and associated regulations. It is expected that the PSU will conduct at least one formal training session focused on waiver programs each quarter and that waiver training programs will be conducted at least three times each year in regions specified by the State.

5.2.1.4 Electronic Claims Submission Support

The State requires that electronic media options be made available to providers for claims submission. The PSU is responsible for provider outreach, developing training materials, conducting training seminars, and assisting providers in the installation and maintenance of the electronic claims submission tools.

5.2.1.5 Administrative Reviews and Appeals Support

The Contractor is directly responsible for performing administrative reviews and supporting claims appeals. The PSU supports this process by informing providers about the process and providing assistance as needed throughout the review or appeal process.

5.2.1.6 Fraud, Waste, and Abuse Identification and Referral

The PSU is responsible for educating providers to prevent instances of fraud, waste, and abuse and any potential penalties resulting from these actions. The PSU must also report any suspicions of fraud, waste, or abuse identified while performing its primary functions. The State's Surveillance and Utilization Review Unit, operated by the Medical Policy and Review Services Contractor, shall review fraud, waste, and abuse cases.

5.2.1.7 Provider Manual Development

To educate providers and provide them with an information resource, the PSU is charged with the development and maintenance of a comprehensive provider manual. Topics in manual must include, but are not limited to:

- Information about the IHCP
- Member eligibility requirements
- Provider eligibility and enrollment requirements
- Medicare and third-party billing processes

- Prior authorization procedures
- IHCP medical policy
- Utilization review process
- Nursing facility level of care, audit, and Preadmission Screening Resident Review (PASRR) procedures for institutionalized IHCP members
- Billing instructions for all claim types

5.2.1.8 Provider Data Table Maintenance

The PSU maintains comprehensive current and historical information about enrolled providers eligible to participate in the IHCP, including PMP enrollment and MCO enrollment information. A provider data set is maintained to support claims processing, prior authorization processing, management reporting, and utilization review reporting and activities. Provider data is entered into Indiana*AIM* using a series of online windows.

5.2.1.9 Provider Analysis

The PSU is responsible for conducting ongoing analysis of operations reports, provider inquiries, and member inquiries to identify and address potential issues or problems identified as a result of the analysis. This analysis includes, but is not limited to, examining claims error reports and statistics in the MAR Subsystem to identify providers that may need additional training or assistance; examining inquiries or complaints to determine if additional training sessions, provider bulletins, or provider manual updates are needed; and reviewing participation statistics. The Contractor is responsible for taking proactive, corrective actions when issues, problems, or focus areas are identified as a result of its ongoing analysis.

5.2.1.10 Business Objective

The primary objective of the PSU is to provide quality customer service to enrolled and potential IHCP providers. The PSU exists to ensure that providers have a reliable resource to answer questions, provide information and instructions, and provide assistance when necessary.

5.2.2 System Support

The Indiana*AIM* system includes the following system features to support the PSU business function:

- Provides an automated tracking and reporting system for provider enrollment applications (from receipt to final disposition), including

tracking and reporting on application status, provider agreements, certifications, and recertifications
- Generates enrollment approval and denial notices and disenrollment notices
- Generates provider recertification notices for specialized transportation providers, nursing facilities, large and small ICFs/MR, and room-and-board facilities
- Provides an automated tracking and reporting system for written, telephone, and electronic provider inquiries which includes retrieval of the date and nature of the inquiry and the date and nature of the reply by correspondence control number (CCN), provider number, and date
- Maintains CLIA information (CLIA number and certification type)
- Accepts adds and changes to the provider data set through an online, real-time environment through the use of the Windows-based screens
- Generates reports, such as audit trail reports of changes to provider data, alphabetic and numeric provider listings, and lists of providers to be deactivated or purged due to inactivity, as specified by the State
- Provides managed care enrollment broker with tape of enrolled PMPs and PMP enrollment information
- Generates and distributes PMP enrollment rosters
- Generates and distributes PCCM PMP certification codes (authorization codes)
- Maintains capitation rate cell

5.2.3 State Responsibilities

5.2.3.1 Review and approve provider enrollment criteria, including criteria for EPSDT screening providers.

5.2.3.2 Review and approve policies and standards regarding provider enrollment, provider training, and provider relations.

5.2.3.3 Review, approve, and revise as necessary all materials before they are distributed to providers (for example, provider bulletins, enrollment forms, billing manuals, and training materials). The State may elect to decline the review of materials.

5.2.3.4 Conduct appeals process for enrollment denials and terminations.

5.2.3.5 Approve the Contractor's training plan and training materials**.**

5.2.3.6 Provide the Contractor with all State-approved, provider-specific payment rate updates, including mass or paper updates. Certain rates may be calculated by the Contractor at the state's direction, or calculated by third party contractors using data

supplied by the Contractor. The Contractor is responsible for supplying data, calculating rates as directed, and posting rates to the system as required by the state.

5.2.3.7 Approve revisions to all provider manuals

5.2.4 Contractor Responsibilities

5.2.4.1 Establish a provider enrollment unit and a provider relations unit within the Contractor's local operations site. The units will be responsible for provider enrollment, communications, relations, and training. Minimum requirements for each supervisor and provider field consultants for each unit shall include:

- An Associate's degree or equivalent
- Previous relevant experience in a health care or health care payor environment, including familiarity with health care claim billing procedures and procedural coding systems (for example, HCPCS, CPT, ICD-9-CM, ICD-10, etc.), HIPAA X12 transactions, claim forms (CMS-1500, UB-04, etc.), medical privacy and security issues.
- The Provider Enrollment Supervisor is a Key Position.

5.2.4.2 Perform enrollment activities for all provider types. The Contractor must maintain knowledge of all applicable federal and state provider enrollment and certification regulations, and develop and establish detailed guidelines and procedures to ensure proper enrollment of all provider types. Statistically valid sample of enrollment activity will be audited and reported monthly.

5.2.4.3 Ensure all materials required for provider enrollments and updates are available on the IHCP Web site.

5.2.4.4 Process and track, using an automated tracking system, all provider enrollment applications, including returned packets and updates, reviewing for completeness and obtaining missing information, and returned mail. Enroll providers eligible to provide medical assistance services, in accordance with federal and state statutes, rules, and regulations.

5.2.4.5 Process to completion all provider documents including initial enrollments, enrollment denials, and enrollment updates with a maximum turnaround time of 10 business days from receipt. The turnaround time will be based on all Provider Enrollment documents received by the Contractor from the initial receipt in the mailroom to the date the final action is entered into

Indiana*AIM* minus total calendar days of RTP (returned to provider) time. Documents returned to the provider are not considered completed. The Contractor must track and measure turnaround time in an automated tracking system that functions as part of the Indiana*AIM* system. The Contractor shall maintain documentation to support the monitoring of compliance with this standard. The Contractor will ensure information is acceptable and follows approved procedures.

5.2.4.6 Verify required licenses, certifications, accreditations and that provider is not currently sanctioned by the Office of the Inspector General (OIG), and is not on the list of Medicare proscribed providers.

5.2.4.7 Send notification letters of acceptance/rejection/denial of enrollment application within one business day of data entry of provider enrollment decision. Notify each provider of acceptance, rejection or denial as an IHCP provider, and send accepted providers initial packets containing information on documentation available on the Indiana Medicaid website for participation in the program and billing the State for Medicaid services provided to eligible members.

5.2.4.8 Send Civil Rights fact sheets to providers within one (1) business days of enrollment confirmation.

5.2.4.9 Maintain regular communication with all applicable State agencies to perform certification and licensure verification. Verify certification from the appropriate certifying authority in other states for out-of-state providers.

5.2.4.10 Maintain LTC facility certification information.

5.2.4.11 Maintain a file on all approved, denied, and terminated providers. The file for approved providers should contain certification applications, provider agreements, and all correspondence relating to certification or enrollment or resulting in provider data updates. Files for denied providers will include applications and documentation regarding the reason for the denial. Files for terminated providers will include documentation on reasons for termination. Subsequent updates or additions to the file shall be date-stamped and initialed by Contractor staff that updated the file. Audit trails need to clearly track updates to enrollment files.

5.2.4.12 Image all provider enrollment materials, including all forms, letters, documentation supporting the enrolment, and any other

materials associated with the enrollment process as directed by the State. Make images available to State Indiana*AIM* users by hypertext link or via CRLD. This is new functionality, and must be operational by July 1, 2008. All historical provider files must be imaged and associated for reference by January 1, 2009.

5.2.4.13 Recertify providers annually, as directed by the State, by provider type.

5.2.4.14 Mail termination notices to providers. Notices to involuntarily terminated providers are subject to 100 percent second party review for accuracy and completeness of documentation.

5.2.4.15 Maintain, and revise as necessary, all provider agreements to conform with all applicable Federal and State statutes, rules, and regulations. Revisions shall be made within ten business days of requests by the OMPP. The Contractor shall notify providers in writing of any changes made.

5.2.4.16 Identify and notify all providers due for recertification 60 business days prior to the due date.

5.2.4.17 Coordinate provider association meetings with the OMPP, including**:**

- Develop a draft agenda for State review within ten business days prior to the scheduled meeting.
- Incorporate any changes requested by the State prior to the meeting.
- Provide a summary of the issues or problems to be discussed for distribution at the meeting.
- Provide and distribute meeting minutes in a State-approved format documenting the results of the meeting within ten business days following the meeting.
- Follow up on provider association questions or concerns as necessary, within ten business days following the meeting.

5.2.4.18 Provide information to providers requesting member eligibility when such information is no longer available through EVS, website, or regular provider call center inquiry within five (5) business days.

5.2.4.19 Load rate information to the Provider file within five (5) business days of receipt of complete rate information from the State. Develop and implement quality assurance procedures to ensure the accuracy of the loaded rates.

5.2.4.20 Ensure that all provider-related reports are accurate and delivered to the State in the specified period of time.

5.2.4.21 Develop training and QA functions to ensure that managed care PMP and waiver providers are properly enrolled.

5.2.4.22 Designate staff resources to establish and perform a regular and ongoing QA process. The QA process shall be conducted, at a minimum, on a monthly basis and shall include comprehensive reviews of a statistically valid sample of provider enrollment files and updates to enrollment files to ensure the accurate enrollment and updates of providers into Indiana*AIM*. This QA process shall include a representative sample of managed care PMP and waiver program providers. Quality Assurance shall be conducted by staff who independent of those performing the work, and reporting through separate channels to management.

5.2.4.23 Submit a monthly report summarizing the provider quality assurance (QA) activities performed during the month. The report shall include a description of the activities performed, a detailed analysis of the QA review findings, statistics summarizing the findings, a discussion of problems identified and how and when the Contractor plans to correct problems, and the steps the Contractor has taken to prevent the problem from recurring.

5.2.4.24 Mail claim forms and other documents to providers within five business days of request for the forms.

Provider Recruitment

5.2.4.25 Meet with the State regularly and in advance of preparing the Annual Business Plan to discuss recruitment focus areas for the upcoming year.

5.2.4.26 Conduct ongoing research to identify non-participating providers and determine the reasons for non-participation. Analyze Management and Administrative Reporting (MAR) reports, phone inquiries, and written inquiries to detect trends, identify problems, and develop and implement appropriate interventions. Report findings to the State monthly.

5.2.4.27 Develop and implement strategies to increase provider participation and to recruit new and qualified providers. Monitor the effectiveness of the strategies and report the results on a monthly basis to the State.

5.2.4.28 Conduct outreach activities to recruit and retain providers. Conduct outreach activities to those providers that have left the IHCP to encourage them to reapply to become an IHCP provider.

5.2.4.29 Coordinate provider recruitment activities with provider enrollment and provider relations functions.

5.2.4.30 Perform targeted provider recruitment, enrollment, and training as needed, by provider type, to encourage participation and increase access to care (for example, EPSDT, dental, waiver).

Provider Relations

5.2.4.31 Staff provider relations and member hotline toll-free phone lines (for Indiana and the contiguous states) from 8 a.m. to 6 p.m., Indianapolis time, Monday through Friday excluding State holidays.

5.2.4.32 Maintain a sufficient number of telephone lines and personnel to staff the lines so that:

- Ninety-five percent of all calls are answered on or before the fourth ring.
- No more than five percent of incoming calls can ring busy.
- Automated menus are efficient and are approved by the State. All menu selections except the most basic (English or Spanish?, Provider or Recipient?) have an option to select a live operator. From the time a user chooses a live operator, ninety-five percent of calls are answered by a live person within one minute. Hold time must not exceed one minute.
- The average hold time is 30 seconds under normal business activities. Communicate to the State exceptions to this target.
- Call length is sufficient to ensure adequate information is imparted to the caller.
- Services are available in both English and Spanish.
- The Contractor shall have a language line available for translation of other languages.

5.2.4.33 Obtain State approval prior to limiting the number of topics that can be addressed by the caller.

5.2.4.34 Provide reports to monitor compliance with the above requirements. The reports must contain the detailed information to validate the performance of the above requirements.

Technical Assistance and Training

5.2.4.35 Develop, and submit to the State for approval, a provider training plan annually at the beginning of the contract year and update the plan as necessary. Training plans shall include

optional workshops for specialty provider types, such as waiver, managed care, or EPSDT.

5.2.4.36 Use Indiana*AIM* provider and MAR reports to identify trends, evaluate current training needs, and develop appropriate preventive training plans on an ongoing basis.

5.2.4.37 Educate providers, free of charge, about all IHCP programs; the claims processing system; proper billing and prior authorization procedures through workshops, training sessions, presentations at professional association meetings, or individual training as needed or as required by the State; and the production and distribution of provider manuals and bulletins. Education concerning managed care programs will be handled by the designated managed care provider representative with assistance provided by the Contractor regarding claims, billing information, or directing providers to appropriate representatives.

5.2.4.38 Conduct at least six one-day workshops each quarter. These shall be at various geographic locations in Indiana as directed by the State. Conduct an annual three-day workshop in Indianapolis, with three breakout sessions in most time periods. Coordinate with the State and other contractors as directed by the State. Provide seating for at least 80 persons in all workshop sessions.

5.2.4.39 Supply professional, trained provider field consultants to provide direct assistance to providers with claims payment problems, including on-site appointments. At a minimum, one provider field consultant shall be assigned to meet with each provider association group in the following specialties: physician, osteopath, hospital, long-term care, home health, dentistry, pharmacy, durable medical equipment, mental health, podiatry, optometry, chiropractor, and Federally Qualified Health Centers/Rural Health Centers. The provider consultant staff will conduct a minimum of 300 onsite visits per month with providers to address claim payment and policy matters. One visit is defined as a meeting of at least thirty minutes with representatives from one or more provider offices / facilities. Provide monthly documentation to the State on all visits and meetings held by this staff, including but not limited to location, length of meeting, and category of topics discussed.

5.2.4.40 Each field consultant shall be cross-trained, and each consultant is required to specialize and be knowledgeable about the IHCP policy and billing procedures in the provider specialty area to which each consultant has been assigned. The provider field consultants will be responsible for follow-up to

all issues raised at provider association meetings until each issue is resolved. Resolution of issues will require coordination with appropriate staff.

5.2.4.41 A field consultant shall be assigned to assist with the HCBS waiver and 590 programs. A field consultant must be assigned to managed care, and a field consultant must be assigned to the EPSDT and Care Coordination for Pregnant Women programs.

5.2.4.42 The Contractor may allow provider field consultants to reside in the area which they serve; however, the Contractor must specify the mechanism that will be used to ensure that these consultants are kept up to date about changes as they occur. Each field consultant shall be supplied with the materials and equipment necessary to perform the required services efficiently; this includes at a minimum, a laptop computer, high-speed (cable, DSL, satellite, cellular, or equivalent) remote connectivity to Contractor supported systems, and a cell phone with unlimited Indiana calling.

5.2.4.43 Provide the necessary support staff to each field consultant to ensure that the field consultant will be able to use 80 percent of his or her working time responding to provider inquiries, 10 percent of his or her total working time devoted to provider recruitment as requested by the State, and 10 percent for time reporting, attending administrative meetings, and continuing education.

5.2.4.44 Respond to provider calls within one (1) business day. Response calls shall be between the hours of 8 am and 5 pm of the most prevalent time zone in the field consultant's assigned territory.

5.2.4.45 Provide a publications manager who will be responsible for managing the development of a system for formatting, drafting, editing, reviewing, and distributing publications and correspondence. The Publications Manager is a Key Staff position.

5.2.4.46 Ensure that provider field consultants and provider communications/relations staff are aware of provider training and inquiry needs and that such training and inquiries are documented, tracked and resolved in a reportable fashion. Field consultants shall be willing and able to provide on-site support to a provider within two weeks of the provider’s request.

5.2.4.47 Establish procedures to ensure that off-site provider field consultants are kept up-to-date of policies and procedures.

5.2.4.48 Supply and staff toll-free telephone lines (for Indiana and contiguous states) for provider and member inquiries about enrollment, billing, covered services, or claim payment. Staff that perform this function shall have at least two years of health care or telephone customer service experience, and be specialized to respond to the specific needs of particular provider types or specialties. While cross training is also necessary, specialists with a more thorough understanding of a specific provider type or specialty's needs will provide more knowledgeable and accurate information to providers.

5.2.4.49 Develop a comprehensive, internal training plan for all provider staff. This training plan shall address the issue of staff turnover and how the Contractor proposes to train and support positions where turnover is common. The plan shall also include ongoing training activities or processes to ensure that all staff keep policy knowledge current.

5.2.4.50 Develop a training program and materials (and update as necessary) to ensure that all provider services staff are equipped to supply accurate, complete, and consistent answers to provider inquiries. Staff shall have access to necessary supporting documentation and shall have a thorough understanding of provider issues to ask relevant questions and understand all areas that are impacted by provider's inquiry. The Contractor must ensure supporting documentation is updated on a regular basis and staff is informed of any changes.

5.2.4.51 Employees must complete at least a two week training course and a minimum of one week of shadowing an experienced call center person prior to staffing a phone line.

5.2.4.52 Vendor must maintain a listing of persons certified to staff a specific phone queue. An employee may not staff a phone queue for which he or she has not been certified.

5.2.4.53 Implement call recording and sampling of calls for quality review of answers and customer friendliness.

5.2.4.54 Develop, distribute, and evaluate provider training questionnaires from all training sessions, and provide the State with a summary of provider responses within ten business days of the training sessions. Maintain a listing of all providers who participate in the training sessions.

5.2.4.55 Develop and submit to the State an Annual Provider Training Plan within 45 calendar days of the beginning of the calendar year and within five business days of updates.

5.2.4.56 Maintain an automated system for tracking and reporting written and telephone inquiries that ensure online retrieval of the date and nature of the inquiry, provider name and number, and the date and nature of the reply. Analyze, evaluate, and make changes in operations based on the results of the analysis of responses to improve accuracy and efficiency.

5.2.4.57 Provide the State with monthly reports showing the timeliness and substance of responses to all provider inquiries via the toll-free phone lines, local calls received, and written inquiries.

5.2.4.58 Prepare an accurate and thorough written response, as directed by the State, to 98 percent of all written provider and member correspondence (inquiries) within ten business days of receipt of the provider's correspondence by the Contractor. Respond to the remainder within 15 business days of receipt. Written responses must be technically proficient.

5.2.4.59 Maintain an e-mail address or portal to allow providers to submit secure or encrypted questions and inquiries. Respond to all such inquiries by secure portal or encrypted e-mail in the same timeframe and with the same proficiency required for written responses.

5.2.4.60 Prepare an accurate and thorough response, as directed by the State, to all written correspondence from state and federal legislators, the Governor, and the FSSA Secretary within three business days of receipt. All responses must be technically proficient. Provide the State with copies of the Contractor's response on request.

5.2.4.61 Refer all news media inquiries to the State.

5.2.4.62 Maintain a history of inquiries made by providers and the inquiry responses. Detailed information must be maintained online for a period of three months. Summary information must be stored in CRLD for a period of five years.

5.2.4.63 Provide the State with separate monthly reports on all calls placed by providers and members to the Provider Relations and member 800 lines and local calls and the timeliness of written correspondence for the prior month's activity. The reports should include information on busy rates, number of calls, a

summary of the type of call, the provider that made the call, and other information to monitor Contractor responsiveness. The reports shall be submitted within five business days of the end of the reporting month.

5.2.4.64 Provide the State with monthly qualitative and quantitative reports summarizing all calls answered and timeliness of written correspondence, according to State specifications. The reports should include information on the provider types, types of calls, and other information.

5.2.4.65 Supply phone company reports of all line activities, busy signals, hang-ups, and non-connects as well as internal reports of hold time, percentage of calls answered within 120 seconds, and the number of calls answered. The reports shall be submitted to the State within five business days from the end of the month.

5.2.4.66 Supply providers with HCPCS and all other billing code set listings, HIPAA companion guides, narratives, and updates upon provider request. Information will be available via the IHCP Web site. If requested by providers, the information must be available in hardcopy format.

5.2.4.67 Provide technical assistance and training to EPSDT providers as follows:

- Coordinate with the bimonthly Clinical Advisory Committee regarding contents of the EPSDT provider manual and periodicity schedules.
- Produce and distribute EPSDT provider lists to the OMPP and the State Department of Health

5.2.4.68 Prepare and submit a provider services transition plan that addresses staff turnover issues and tracking of outstanding provider issues. The plan should ensure that provider problems, questions, or concerns are not lost when there is a change in Contractor staff.

Electronic Claims Submission Support

5.2.4.69 Inform providers and software vendors and service bureaus about electronic billing, automated remittance, and electronic fund transfer options, and work with providers and software vendors and service bureaus to finalize appropriate formats for the data transfer.

5.2.4.70 Conduct provider and MCO training and training for State-designated organizations, including, when necessary, personnel from the State and other contractors.

5.2.4.71 Target for special training those providers and MCOs that have been identified as having an abnormal number of claims denied or suspended.

5.2.4.72 Maintain, and submit to the State, a listing of all providers (by provider type) that participate in training sessions within ten (10) business days of the session. Provide a summary report at the end of each quarter indicating the dates of each session, the number of providers attending, and the topics covered.

Provider Manual Development

5.2.4.73 Supply all providers and MCOs, with the most current and complete provider manuals and supporting materials. Information will be available via the Web site. If requested by providers, the information must be available in hardcopy format at no charge.

5.2.4.74 Supply all providers with State-approved posters to help providers comply with civil rights requirements. Posters will be mailed within ten (10) business days.

5.2.4.75 Draft, obtains State approval of, print, and distribute provider billing manuals, revisions to provider billing manuals, and HIPAA companion guides. Draft manuals should be comprehensive and reviewed for content and formatting prior to submission to the State. Requested Provider Manual revisions must be provided to the State for review within ten business days of the request. Prior to submission for State approval, the State reserves the right to require the Contractor to work with and solicit input form the provider community or other entities about the content of the provider manuals and documentation.

5.2.4.76 Update all manuals, including Provider Manuals, internal procedure manuals, and Operating Procedures Manuals, every six months to include information sent to providers in the provider bulletins and to reflect changes made during the quarter, and as specified in Section 20 of this RFP. It is the Contractor's responsibility to review the manuals periodically to determine if clarifications and updates are needed.

5.2.4.77 Once approved by the State, mail all provider manual updates, including HealthWatch/EPSDT and Waiver Program Provider Manuals, within ten business days of State approval.

5.2.4.78 Provide a Central Librarian, in addition to and separate from the Publications Manager, to control versions of documentation; update manuals, training manuals (for Contractor staff and providers), and supporting documentation appropriately; and coordinate the documentation review process.

5.2.4.79 Draft and distribute, with State direction and approval, up to 50 provider communications and four member communications per calendar year. These may include periodic bulletins, special bulletins, or notices. The State and Contractor will mutually agree to pricing for bulletins above these caps.

All communications shall be professionally written by the Publications Manager and appropriate staff. Staff shall have experience in English, technical writing, communications, or a related field. Member communications shall appropriately target the audience. Bulletins shall be in a user-friendly, easy-to-understand newsletter or newspaper-style format. Bulletins shall include information on billing issues, IHCP developments and initiatives, issues related to IHCP services and policy, and general information of interest. The Contractor shall provide a draft of the bulletin for State review and approval no later than 15 business days before the bulletin is to be issued. The Contractor shall produce the bulletin during the Transition Phase.

5.2.4.80 Prepare and send to the State for approval, drafts of provider bulletins and provider manual revisions within ten business days of the State request.

5.2.4.81 Prepare, and send to the State for approval, drafts of member bulletins within ten business days of the State's request.

5.2.4.82 Make provider manual revisions and provider bulletins available via the IHCP Web site within ten business days of approval by the State, or sooner, as requested.

5.2.4.83 Mail recipient bulletins within ten business days of approval by the State, or sooner if requested.

5.2.4.84 Provide access to billing manuals and provider bulletins to the State, all provider associations, 590 facilities, and other entities as specified by the State via the IHCP Web site.

5.2.4.85 Generate provider mailing labels on request from the OMPP within five (5) business days of the request.

5.2.4.86 Generate a quarterly enrolled provider file by County, by specialty, and provide copies to FSSA and ISDH.

5.2.4.87 Generate an alpha-enrolled provider file quarterly. Provide one copy to the FSSA.

Provider Data Maintenance

5.2.4.88 Update the provider data set on a daily basis to reflect changes brought to the attention of the Contractor by the State, providers, or its own staff. Maintain an online audit trail of all changes.

5.2.4.89 Establish methods to edit and verify the accuracy of provider data entered into Indiana*AIM*.

5.2.4.90 97% of processed enrollments and updates shall be completed without a defect.

5.2.4.91 Periodically purge inactive provider records on a schedule and using criteria specified by the State. Keep all files and records, including purged provider files and records according to the State-mandated retention schedule.

5.2.4.92 Provide PMP information to MCOs and the State's enrollment broker and PCCM administrator as specified by the State.

5.2.4.93 Maintain, and coordinate with the rate-setting Contractor(s), updates to institutional rates on the Provider Master Table.

5.2.4.94 Maintain a record of the provider network of PMPs, specialists, and all other providers appropriate to each managed care delivery system.

5.2.4.95 Generate IHCP provider information electronically to MCOs as specified by the State.

5.2.4.96 Maintain LTC facility certification data as specified by the State.

5.2.4.97 Maintain PMP provider enrollment and disenrollment information and MCO information.

5.2.4.98 Prepare and send change-of-ownership letters for LTC facilities.

5.2.4.99 Distribute in a timely and accurate manner PMP enrollment rosters and certification code updates.

Fraud, Waste, and Abuse Identification and Referral

5.2.4.100 Identify and communicate leads on potential fraud and abuse cases to the State-mandated contacts.

5.2.4.101 Provide to the State-mandated contacts, on a weekly basis, a list of newly enrolled providers.

5.2.4.102 Identify the need for establishing reciprocal arrangements with other states to monitor care given to IHCP members in out-of-

state facilities, establish such arrangements, and monitor the arrangements.

5.2.4.103 Perform reciprocal care monitoring activities for other states requesting such arrangements and as directed by the State.

5.2.4.104 Participate in monthly meetings (or more frequently) with other contractors as deemed necessary by the State. Prepare minutes within ten business days of meetings.

Coordination Activities

5.2.4.105 Update the Provider Manuals to include changes in prior authorization procedures received from the State or contractors designated by the State.

5.2.4.106 Update the Provider Manuals to include changes in billing procedures received from the State or contractors designated by the State.

5.2.4.107 Meet with the State or contractors designated by the State regularly to discuss provider training topics and needs as they relate to Prior Authorization, Medical Policy, and SUR.

5.2.4.108 Post provider bulletins and newsletters to the IHCP Web site that contain information related to PA, SUR, Medical Policy, and Drug Rebate.

5.2.4.109 Coordinate with the State and contractors designated by the State to resolve issues regarding the Provider Services business function.

5.2.4.110 Transfer issues to the State or contractors designated by the State for resolution.

5.2.4.111 Support administrative review and appeals activities performed by the State and contractors designated by the State by providing copies of documents as requested.

5.2.4.112 Maintain accessible reference files of provider background information as directed by the state to assure that providers with a known history of fraudulent or criminal activity in Indiana or other states are not allowed to become Medicaid billing or practicing providers.

5.2.4.113 Provide for the receipt and processing of fingerprints and submission to law enforcement agencies for background screening of providers, if directed to do so by the state.

5.2.4.114 Maintain records of ownership of provider businesses and relate individual owners to each provider number they are associated with. If directed by the state or under application of state rules to exclude an individual from the Medicaid program,

identify each associated provider for exclusion within five business days; submit to the state for determination of the action to take.

5.2.4.115 Provide for the recording of information on site visits to provider facilities, whether done by field representatives at the direction of the state or by state personnel. Site visit information may be used in determining whether a provider should be enrolled in the Indiana Medicaid program.

5.2.4.2 Consult the CLIA/OSCAR federal laboratory interface to assure that laboratories are properly credentialed to serve as Medicaid providers.

5.2.4.3 Enroll providers to receive Electronic Funds Transfer (EFT) and maintain information to assure that EFT payments are issued only to the correct account.

5.2.4.4 Maintain physical provider files in logical order by provider number. Properly file all materials within three business days of completion. Maintain working records so that any paper file can be produced at the state's request within one day or as requested.

5.2.4.5 Record and maintain provider e-mail addresses when available. At the state's request or according to business rules approved by the state, issue provider alerts, notifications and bulletins by e-mail. Maintain records of all e-mails sent.

5.2.4.6 Maintain and enforce consistent provider name and address conventions to standardize records, reduce errors, provide more efficient referencing and avoid duplicates. Use zip code validation software on a periodic and systematic basis to increase accuracy of provider address records.

5.2.4.7 Maintain information on managed care individual providers and practitioners, even if they do not participate in fee for service Medicaid.

5.3 Reference Data Maintenance

5.3.1 Overview and Business Objective

The Reference Data Maintenance business area's primary function is to provide a repository of current and historical information to be used to process IHCP transactions. The Indiana*AIM* Reference Subsystem collects and maintains the information used to define and enforce State policy as it relates to covered services, prior authorization requirements, medical policy, service restrictions, and reimbursement. Other business areas, such as Claims Processing, Prior Authorization, Third-Party Liability, and Utilization Management, access the Reference tables during

system processing to retrieve stored data used to make pricing determinations, post edits and audits, or secure other Reference data. Reference file data must be, or have the capability of being, date-specific; and, following pricing file updates, the pricing data for prior periods must be stored and used to price claims with dates of service prior to said updates.

Data stored on the Reference tables includes information about:

- Pricing for HCPCS procedure codes; NDC, UPC, and HRI codes; diagnosis-related groupings (DRGs); level of care; and Indiana-specific codes
- Revenue codes
- ICD-9 and ICD-10 procedure and diagnosis codes
- Lab fee schedules
- Medicare fee schedules (RBRVS)
- Edit and audit criteria
- Edit dispositions (pay, suspend, claim correction, and deny)
- Error and remittance text information and explanation of benefits (EOBs)

Reference data is updated through batch processes and online updates. Typically, batch updates are performed on the following schedule: weekly for NDC, UPC, and HRI codes; quarterly for HCPCS-coded immunizations; quarterly for State-specific codes; and quarterly for HCPCS procedure codes, ICD-9 and ICD-10 procedure and diagnosis codes, and error disposition files. Most updates are received via tape from sources contracted by the State (such as AdminaStar) or from Federal entities (such as CMS). At times, manual on-line updates may be performed when an insignificant number of changes are necessary. Changes occurring in Indiana*AIM* are tracked through audit trails that provide a before-and-after image of changes occurring in the system. By reviewing audit trails, changes can be validated to ensure accuracy.

5.3.1.1 Business Objective

The objective for the Reference Data Maintenance function is to provide access to timely, accurate information to accurately process claims in accordance with State policy.

5.3.2 System Support

Indiana*AIM*'s automated features supporting this function include the following:

- Provide online access and update of Reference data.
- Maintain online audit trails of changes made to Reference tables.
- Generate reports to support the Reference Data Maintenance function.
- Provide online update capabilities

5.3.3 State Responsibilities

Request, as necessary, manual updates.

5.3.3.1 Review and approve manual and electronic updates to the Reference tables as necessary.

5.3.3.2 Review and approve new edits and audits, and review and approve Contractor-proposed changes to edits and audits prior to the change being made.

5.3.3.3 Advise the Contractor of services that are non-covered.

5.3.3.4 Provide the operational and policy parameters used by the Contractor to design and modify edits and audits.

5.3.3.5 Request and approve mass updates (for example, regular and irregular updates) to tables as necessary.

5.3.4 Contractor Responsibilities

5.3.4.1 Process all procedure and billing code updates, including a quarterly HCPCS procedure code tape update and all code set periodic and special updates as necessary in accordance with provision of the Contractor's work plan approved by the State**.**

5.3.4.2 Systematically update DRGs, including base rates, capital, medical education, and weights, within two business days of receipt or State request. Update the DRG Grouper to the State's designated Grouper version on a time line agreed to with the State.

5.3.4.3 Update Reference tables with HCPCS procedure codes and all other code sets, in accordance with State law**.**

5.3.4.4 Systematically update annual ICD-9 and ICD-10 procedure and diagnosis codes and all other code sets within five business days of receipt and before the effective dates of the codes.

5.3.4.5 Update anesthesia RVUs on basis of a mutually agreed schedule between the Contractor and the State**.**

5.3.4.6 Processes update tapes for NDC, UPC, and HRI**.**

5.3.4.7 Correctly apply updates to the Reference tables within two business days of request by the State.

5.3.4.8 Proactively review and analyze file and code set updates to ensure information is accurate, and provide reports to the State detailing the results of the Contractors review on a monthly

basis or as requested by the State. (for example, procedure codes are covered, etc.).

5.3.4.9 Establish new or revise existing, pricing methodologies and specific pricing criteria for claims processing tables, as approved by the State. Review pricing methodologies and criteria annually, and make recommendations to the State to improve pricing methods.

5.3.4.10 Update the benefit limitation and service conflict criteria to be applied through the use of the edit and audit criteria tables, as directed or approved by the State**.**

5.3.4.11 Contract with and pay for data from First Data Bank or such other vendor as may be approved by the State. Apply updates to Federal MAC and DESI/IRS via the First Data Bank (FDB) update file and Rebate tables as received by the Drug Rebate Contractor in accordance with Federal effective dates, unless directed otherwise by the State. Changes in rebating labelers will be submitted to the Contractor from the Pharmacy Benefit Manager (PBM) Contractor for maintenance of the Drug Rebate File. These updates will be sent to the Contractor from the PBM vendor in a system-approved format.

5.3.4.12 Update pricing information and other data on the Reference tables in accordance with State procedures.

5.3.4.13 Establish a pharmacy quality assurance procedure for State approval, and provide a Pharmacist Reviewer to carry out the quality assurance procedure and assure that all requirements of this section are met. The Pharmacist Reviewer is a Key Position. Quarterly, review and revise all reimbursement rates, as necessary, associated with injectable drugs, including vaccines that are claim-submitted with other than NDCs. Activities shall be completed in accordance with the State-defined methodology. The Contractor shall also be responsible for:

- Establishing benchmark drug products that represent the drug referenced by the narrative description of each code
- Ensuring that reimbursement rates for non-NDCs are appropriate for, and applicable to, the dose and quantity specified by the code narrative
- Clarifying doses and quantities where narratives for non-NDC code drugs are not explicit, establishing appropriate reimbursement rates based on determination, and notifying providers accordingly

5.3.4.14 Within 30 business days of the end of each calendar quarter, notify the State, in writing, of the date of the completion of the prior quarter's updating. The Contractor shall specify how many codes and rates were reviewed, how many were revised upward and downward, and how many remained unchanged. The Contractor shall also include a listing of new codes that were added, what drugs the codes represent, the effective date, the assigned reimbursement rate, and the date that the Contractor notified providers of the new codes. All changes to codes and rates are subject to State approval.

5.3.4.15 Develop, and crosswalk alternatives for procedure codes, taxonomy, modifiers, level-of-care, and other HIPAA required elements within 60 business days of direction by the State.

5.3.4.16 Respond to State requests for research of claims payment problems within a mutually agreed upon time frame between the State and the Contractor. Responses to State requests must include an accurate diagnosis of the problem, a description of how it will be fixed, and a time estimate for fixing the problem. If system changes are necessary to fix this problem, the Contractor must demonstrate that this fix is functioning correctly using the integrated test facility.

5.3.4.17 Perform online updates to Reference tables**.**

5.3.4.18 Maintain the edit and audit criteria on Indiana*AIM*.

5.3.4.19 Perform batch updates of Reference tables from other update services (for example, HCPCS, ICD-9, UCC, DRGs, and DUR) on a schedule determined by the State.

5.3.4.20 Coordinate Reference table updates internally when units of service change on services, including those requiring prior authorization.

5.3.4.21 Perform mass updates to the Reference tables as specified by the State.

5.3.4.22 Coordinate with provider assistance weekly to identify and resolve Reference file problems. When identified and confirmed, update Reference File to correct the problem within two business days of approval of a Change Request through the State's Change Control Process to correct the problem. Send banner page notices to inform providers in advance when problems are found and in the process of being corrected. If mass adjustments or reprocessing are needed, a banner page or

individual notice that includes affected claims and appeal rights in accordance with State's policy shall be provided to notify providers upon completion of the correction.

5.3.4.23 Proactively assist in developing edit and audit criteria or recommend changes to edit and audit criteria to reduce claims suspense rates. All changes to edit and audit criteria must be approved by the State (for example, maximize use of modifiers).

5.3.4.24 Update and deliver changes to the resolution manual pages to the Publications Unit as specified in Section 20, General Contract Requirements.

5.3.4.25 Process and activate in the system weekly NDC Drug file updates within three (3) business days of receipt.

5.3.4.26 Obtain and maintain a Master Drug file of all available NDC-, UPC-, and HRI-coded products.

5.3.4.27 Process state-approved limits and restrictions for each NDC that is received in a systematic file from the Pharmacy Benefit Manager within three business days of receipt.

5.3.4.28 Submit monthly status reports to the State describing changes made to the Reference tables and what prompted the change, identifying newly discovered maintenance items requiring update, and the date of file correction.

5.3.4.29 Develop a work plan for major Reference File update projects that delineates planned activities in relation to the Reference Data Maintenance function. The work plan should delineate daily activities related to non-routine HCPCS and DRG maintenance. Work plans should be updated monthly to show progress toward existing activities and defining new projects. Work plan updates must be submitted to the State in accordance with the mutually agreed upon update schedule

5.3.4.30 Ensure that the Reference tables accurately reflect State policy to support system edits and audits.

5.3.4.31 Develop a quality control process to ensure integrity of the Reference files (for example, claims price correctly, edits and audits post according to specifications, etc.).

5.3.4.32 Ensure modifiers are correctly identified and linked to appropriate codes.

5.3.4.33 Provide definition for all modifiers, including how the system processes the modifiers to all relevant Contractor and State staff as determined by the State.

5.3.4.34 Generate, and disseminate to providers, a bulletin outlining information or changes regarding HCPCS procedure codes, PA requirements, modifiers, deleted codes, added codes, new codes, limitations, and covered and non-covered codes in accordance with State policy, rule, law or direction.

5.3.4.35 Provide listings of the Reference files (for example, HCPCS procedures, modifiers, diagnoses etc.) in the requested format to the State within one week of receipt of the request.

Coordination Activities

5.3.4.36 Coordinate with the Medical Policy and Review Services Contractor to evaluate changing practices within the medical community.

5.3.4.37 Evaluate codes to determine if they represent covered or non-covered services. Develop a process to transfer information to other contractors as directed by the State. Evaluate codes to determine if they should be subjected to TPL editing.

5.3.4.38 Develop and coordinate processes to transfer information to the State or State-mandated Contractor.

5.3.4.39 Process reference file updates as received by the Medical Policy and Review Services Contractor or as specified by the State.

5.3.4.40 Develop and maintain a communication method for transferring data to other contractors regarding issues relating to their business function. Facilitate access to reference data by other contractors as directed by the State.

5.3.4.41 Interface with the other State contractors to resolve issues regarding and transmit business function-related information no less than weekly.

5.3.4.42 Maintain all other external reference files that may be necessary to operate Indiana*AIM*, including NCPDP, NDC, CDT (Dental codes), county codes, zip codes, and aid categories. Maintain any and all tables required for the reference subsystem, including future changes as required for

Medicaid processing, required to comply with State and federal laws and rules, and as directed by the State.

5.3.4.43 Any changes to reference files must be submitted to the State's Change Control Process for approval prior to making the change.

5.3.4.44 Maintain all files, connectivity and interfaces necessary to support other state contractors, including the Pharmacy Benefits Manager.

5.3.4.45 Maintain and update as required all HIPAA-mandated transactions and code sets, and all other tables, files and information required to comply with federal and state laws and rules. Update companion guides as transactions or code sets change and at the direction of the state.

5.3.4.46 Acquire and maintain Diagnosis Related Grouping (DRG) software and utilize as directed by the state.

5.3.4.47 Subscribe to a drug file maintenance service or contract for the receipt and maintenance of national drug codes (NDC) with a vendor approved by the state.

5.4 Member Eligibility Maintenance

5.4.1 Overview and Business Objective

The IHCP eligibility determination process begins with the Division of Family Resources (DFR) Eligibility Process. When an applicant requests public assistance, the DFR enters his/her information into the Indiana Client Eligibility System (ICES). ICES processes the member information and determines the individual's eligibility. If the applicant is eligible, the demographic data, eligibility information, and any limitations such as spend down or long-term care liability is transferred to Indiana*AIM* during the daily ICES/AIM interface.

If data has been modified in ICES (for example, a change of address), the Indiana*AIM* data will automatically be updated with the new information. Member identification (RID) numbers are assigned by ICES. If the member does not already have a member identification card, a card will be issued from Indiana*AIM*. Individuals eligible for 590 services (for example, individuals residing in State mental institutions, or in Department of Health facilities) are managed separately. In these cases, the facilities identify members that are eligible for coverage. Member information is manually sent to the Indiana*AIM* Contractor where the information is entered into the system. The Contractor then provides the facility with the new member identification number. Plastic identification

cards are not provided to 590 members. Information for persons eligible for medical review determinations and PAS/RR determinations is forwarded from the respective systems.

The Member Eligibility business function at the State level is composed of three primary functions:

- Maintenance of member data
- Report production and support of member eligibility policy development (for example, reporting and research as necessary to support State policy decisions)
- Oversight of member identification card distribution

5.4.1.1 Member Data Maintenance

The primary purpose of Member Data Maintenance is to maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for IHCP. The maintenance of member data is required to support the claims processing and reporting functions. Member eligibility data is also used to support the Eligibility Verification System (EVS). EVS allows providers to check a recipient's eligibility and managed care status at the time service is provided. Additional information about EVS is in Section 5.5 Eligibility Verification System.

5.4.1.2 Reporting and Policy Support

Member Eligibility functions within Indiana*AIM* provide a wide array of reporting options. Many of these reports are used to track eligibility activity and detect errors in the interface process between ICES and other state or federal eligibility systems and Indiana*AIM*. This function also supports the State when making decisions that impact IHCP eligibility policies. Member data and reports are used to research questions from the State's eligibility policy unit and provide it with the information necessary to make policy decisions. The Contractor is expected to maintain knowledgeable staff who will be responsible for supporting day-to-day operations activities and analyzing trends to determine appropriate interventions.

5.4.1.3 ID Card Distribution

Individuals eligible for IHCP services are assigned a unique number and provided with a plastic identification card. Because a member may have a card without having a current eligibility segment, it is crucial that member eligibility data is accurately maintained and made available to providers to verify

eligibility status at the time services are rendered. It is also critical that providers know the managed care delivery system through which members are receiving services.

5.4.1.4 Business Objective

The business objectives for the Member Eligibility function are:

- Provide a source of member data to be accessed during processing by other functional areas of Indiana*AIM*.
- Ensure compliance with Federal and State eligibility requirements.
- Permit providers to verify the eligibility of members at the time they are providing services.

5.4.2 System Support

The majority of system functions involved in member eligibility are automated and essentially invisible to the user. Following is a list of system functions associated with the Member Eligibility function:

- Interface with the State or federal eligibility systems daily to receive member data and eligibility information.
- Produce reports showing the characteristics of the IHCP member population, the number of ID cards issued, and errors in the interface process with State eligibility systems. The Contractor must research and resolve all errors.
- Provide online access to a series of windows displaying member data.
- Provide online update capabilities to selected fields to enter level-of-care information and other eligibility information.
- Provide monthly reconciliation of eligibility data on Indiana*AIM* and State eligibility systems.
- Process requests for new and replacement ID cards.
- Generate ID cards.

5.4.3 State Responsibilities

5.4.3.1 Determine which individuals are eligible to receive IHCP benefits, and determine benefit limitations and applicable periods.

5.4.3.2 Daily, provide, on electronic media, member eligibility data required to maintain the Indiana*AIM* member eligibility tables.

5.4.3.3 Arrange for the Contractor, at no cost to the Contractor, to have access to ICES, including network connectivity and security access.

5.4.3.4 Monitor performance relating to eligibility updates and file reconciliation.

5.4.3.5 Approve new, or revisions to existing, reconciliation parameters between State eligibility systems and Indiana*AIM*.

5.4.3.6 Through the eligibility (re)determination process, inform and periodically reinform eligible members of EPSDT services and benefits, according to 42 CFR, Part 441.

5.4.3.7 Review and approve all policy and administrative decisions regarding EPSDT.

5.4.3.8 Provide the Contractor with updates to the current EPSDT periodicity schedule.

5.4.4 Contractor Responsibilities

5.4.4.1 Maintain the Indiana*AIM* member eligibility data set(s), including EPSDT data for eligible members.

5.4.4.2 Notify the State within 4 hours of unsuccessful or incomplete transfer of eligibility files from or to State or federal eligibility systems.

5.4.4.3 Produce and make available within one business day member error reports for each eligibility transaction (such as interfaces with ICES and other State or federal eligibility systems) that fails one or more edits; notify the State of the need to resolve edits if the Contractor cannot resolve them.

5.4.4.4 Resolve eligibility interface transactions that fail due to overlapping eligibility duplicate social security, or other edits as defined by the State within three business days of error.

5.4.4.5 Produce and submit to the State balancing and maintenance reports from the daily update process by noon on the business day following the update.

5.4.4.6 Monitor and maintain edits in place for the daily interfaces with State eligibility systems, and recommend changes to streamline the interface process.

5.4.4.7 Process and apply daily updates to the member tables from State eligibility systems.

5.4.4.8 Enter online add, change and delete transactions for members not transmitted via the electronic update process.

5.4.4.9 Transmit update transactions to State eligibility systems from Indiana*AIM* for Indiana*AIM* -maintained data.

5.4.4.10 Perform online updates to Indiana*AIM* -specific fields when necessary.

5.4.4.11 Produce and mail permanent member identification cards to the mailing address contained in the member tables within three business days after a request for a card has been received.

5.4.4.12 Provide assistance to the State to develop procedures and protocols for member education.

5.4.4.13 Produce, print, and distribute up to four communications annually to recipients or a subset of recipients as directed by the State. If less than four communications are produced in a calendar year, the balance will be carried over to the next calendar year.

5.4.4.14 Ensure that existing and new requirements of state and federal policy are met.

5.4.4.15 Research recipient file discrepancies and take appropriate corrective action. Notify ICES and other State eligibility systems within 15 business days of the discovery of the file discrepancies.

5.4.4.16 Perform reconciliation between the member tables and State eligibility systems on a schedule agreed to by the State and incorporated into appropriate operating procedure manuals, to ensure data integrity, and produce reports in a State-defined format of such activity. Research and analyze reconciliation updates with the OMPP and State eligibility systems to determine error resolution and initiate correction.

5.4.4.17 Produce and submit to the State balancing and maintenance reports from the monthly reconciliation process by 9 a.m. on the third business day following the run.

5.4.4.18 Transmit daily Indiana*AIM* member updates of Indiana*AIM* -maintained data (TPL, restricted members) to State eligibility systems.

5.4.4.19 Maintain appropriate controls and audit trails to ensure that the most current member data is used during each claims processing cycle.

5.4.4.20 Provide online inquiry through the State network access and Indiana*AIM* terminals to member eligibility tables.

5.4.4.21 Provide the State with member reports as determined by the State.

5.4.4.22 Generate and distribute initial, annual, and periodic EPSDT notifications, as defined and scheduled by the State.

5.4.4.23 Generate and distribute initial informing and annual reinforming notices for EPSDT eligibles, as defined and scheduled by the State.

5.4.4.24 Generate and distribute EPSDT notifications to pregnant women and children under age five as defined and scheduled by the State.

5.4.4.25 Provide a full-time EPSDT coordinator as part of the Contractor's staff, who will serve as the EPSDT liaison, Vaccine for Children liaison, and Care Coordinator for Pregnant Women program liaison for the State and who must have the following qualifications:

- Bachelor's degree from an accredited college
- Two years of recent relevant experience with the IHCP

5.4.4.26 Maintain toll-free telephone lines for Indiana and the contiguous states for member inquiries (referred to as the recipient hot line) and personnel to staff the lines so that:

- Ninety-five percent of all calls answered on or before the fourth ring.
- No more than five percent of incoming calls ring busy.
- Automated menus are efficient and are approved by the State. All menu selections except the most basic (English or Spanish?, Provider or Recipient?) have an option to select a live operator. From the time a user chooses a live operator, ninety-five percent of calls are answered by a live person within one minute. Hold time must not exceed one minute.
- The average hold time does not exceed 30 seconds.
- Call length is sufficient to ensure adequate information is imparted to the caller.
- The Contractor must obtain State approval prior to limiting the number of topics that can be addressed by the caller. Contractor shall ensure that a language line is available for translation.

5.4.4.27 Staff member hotline toll-free lines from 8 a.m. to 6 p.m., Indianapolis time, Monday through Friday, excluding State holidays.

5.4.4.28 Provide reports to monitor compliance with the telephone performance requirements. The reports must include the

substantiating details. Analyze, evaluate and make changes to respond to spikes and deficiencies and to improve the quality and efficiency of telephone responses.

5.4.4.29 Provide reports that capture member inquiries to the hotline by subject and number of inquiries. Analyze, evaluate and make changes to respond to spikes and deficiencies and to improve the quality and efficiency of telephone responses. Contractor shall immediately inform the State of trends that are a cause for alarm.

5.4.4.30 Work with State eligibility systems staff when interface information does not pass or was not updated in Indiana*AIM* to research and diagnose the problem and determine the shared solution.

5.4.4.31 Maintain an interface problem log in a format agreeable to the State. The log must track all outstanding interface issues related to ICES and other State or federal eligibility systems, including but not limited to the issue's current Change Order priority. Submit the log to the State on a monthly basis.

Coordination Activities

5.4.4.32 Work with other State Contractors to resolve issues in relation to recipient data. At a minimum, the Contractor must meet bi-monthly with ICES and as necessary with other State Eligibility systems contractors or staff to discuss and review the interface problem log.

5.4.4.33 Provide recipient eligibility extracts to designated state contractors on a schedule specified by the State.

5.4.4.34 Provide technical assistance to designated state contractors when issues with the member eligibility extract occur.

5.4.4.35 Track recipients in the Spend-down program. Use Indiana*AIM* to track medical expenses for each month, then pay claims for the month as directed by the State. Vendor mails summary notices to the recipient and providers. Must accept non-claim medical expense information from the state's eligibility systems.

5.4.4.36 Handle and track recipient inquiries and requests under the HIPAA Privacy Rule, such as requests for alternate communication, delegation of health care surrogate, and requests for accounting of disclosures.

5.4.4.37 Receive and process files from an enrollment broker contractor about special needs and requirements of recipients. Upload the information into Indiana*AIM* and transmit the information to managed care organizations and others as directed by the State.

5.4.4.38 Perform activities related to the chronic disease management program. Generate extracts of information based on selection stratification model supplied by the State for certain disease categories or states. Send extracts to the Indiana State Department of Health (ISDH) nightly. Refresh data on disease states quarterly or a timeframe established by the State and add disease states as directed by the State.

5.4.4.39 Receive and process eligibility and other information from the State or contractors to support eligibility evaluations and nursing home placements, including MRT, HCI and PASRR. Process claims for related services according to rules supplied by the State.

5.4.4.40 Individuals eligible for 590 services (for example, individuals residing in State mental institutions, or in Department of Health facilities) are managed separately. In these cases, the facilities identify members that are eligible for coverage. Member information is manually sent to the Indiana*AIM* Contractor. The Contractor shall enter the information into the system. The Contractor shall provide the facility with the new member identification number. Plastic identification cards are not provided to 590 members.

5.5 Eligibility Verification System

5.5.1 Overview and Business Objective

Indiana*AIM* includes capabilities to perform electronic member eligibility verification functions at the provider's place of service. Eligibility verification system (EVS) provides a real-time, interactive method of ensuring that patients with a Hoosier Health card are currently eligible for IHCP services.

Access to EVS is provided free of charge to providers, billing agents, value-added networks (VANs), and other entities as identified by the State. The Indiana EVS provides a number of distinct functions to accommodate the needs of different provider types, including:

- An automated voice-response (AVR) system, providing telephone inquiry capability to access current member eligibility information and managed care status

- Point-of-service (POS) providing EVS access through: 1) any device submitting a HIPAA and companion guide compliant eligibility request. and 2) a secured Internet site that provides access to eligibility and managed care status information online, real-time from Indiana*AIM*.

Individuals eligible for IHCP services are provided a plastic, embossed identification card. Because the identification card is not a guarantee that the individual is eligible for the IHCP on the date of service, providers of services must be provided with a mechanism for verifying the eligibility of the individual prior to providing services.

There are several mechanisms by which Indiana providers can verify the eligibility of individuals seeking services as IHCP members:

- AVR system – AVR is a digital system by which providers can dial in with a touch-tone telephone; enter their provider identification number for security; and enter a RID, SSN, or HIB to obtain eligibility verification, managed care restrictions, and benefit limitations and usage.
- Submission of 270/271 Transaction – Providers or their billing agents or VANS may submit a HIPAA compliant eligibility inquiry transaction (270). The Contractor responds with a HIPAA-compliant eligibility verification response (271).

5.5.1.1 Business Objective

The objective of the Eligibility Verification function is to permit providers to verify the eligibility of members at the time they are providing services

5.5.2 System Support

The Indiana*AIM* EVS and AVR systems provide the following functionality:

- Provides access to the most recent member eligibility information from the recipient database tables
- Provides real-time access to member eligibility information, including managed care status, for providers via IBM-compatible software or a POS terminal device
- Allows providers to enter recipient information in a formatted screen and routes information to Indiana*AIM* for processing
- Allows providers swipe-card access to member eligibility information stored in Indiana*AIM*
- Provides the ability to print eligibility verification as necessary
- Transmits member eligibility information and a verification number to providers after processing eligibility requests
- Provides information to the AVR system
- Provides access to a secure Internet site for eligibility verification

5.5.3 State Responsibilities

5.5.3.1 Ensure that the daily member file updates from State eligibility systems are available for processing by Indiana*AIM*.

5.5.3.2 Review and approve EVS manuals and other documentation prior to distribution to providers.

5.5.4 Contractor Responsibilities

5.5.4.1 Maintain all eligibility verification systems for IHCP providers to inquire about member eligibility.

5.5.4.2 Provide sufficient inbound toll-free lines so that IHCP providers (in Indiana and the contiguous border states) are connected with the AVR system at least 98 percent of the time. Produce monthly reports documenting compliance with the requirement.

5.5.4.3 Eligibility Verification transactions not submitted through AVR, such as web inquiries and inquiries through Value Added Networks, must be completed within 20 seconds 99.999 percent of the time. Produce monthly reports documenting compliance with the requirement.

5.5.4.4 Provide sufficient inbound communication lines, routing equipment and connections dedicated to receive eligibility inquiries from POS terminals and process all transactions within ten (10) ten seconds. Produce monthly reports documenting compliance with the requirement.

5.5.4.5 Update the automated eligibility inquiry source file daily with data from the most up-to-date member database tables.

5.5.4.6 Provide availability of AVR, POS, and Internet inquiries 23 hours per day, seven days per week, 99.999 percent of the time. No more than two periods of downtime of one hour in length should occur in a 30- day monitoring period. The State may grant a waiver of this requirement under emergency conditions. Routine system maintenance will be scheduled during non-peak processing hours, from 4 a.m. to 5 a.m.

5.5.4.7 Maintain a database containing all necessary information, including eligibility, TPL, and information addressing eligibility limitations.

5.5.4.8 Supply the necessary software, communication lines, and trouble-shooting assistance, free of charge, to providers, billing agents, VANs, and other entities identified by the State to access the AVR feature of the EVS by using standard touch-tone phones.

5.5.4.9 Display (online, real-time), and print when requested, the results of an EVS inquiry.

5.5.4.10 Provide secure, Web-based access for providers to access EVS information.

5.5.4.11 Provide necessary training and assistance to providers and State personnel in installing and using EVS, as needed, and in various geographic regions of the State.

5.5.4.12 Notify the State if the EVS will be down more than 30 consecutive minutes.

5.5.4.13 Produce and make available to the State and providers EVS manuals, reference cards, and other documentation within five business days of changes or updates.

5.5.4.14 Produce EVS-related reports according to State specifications.

5.5.4.15 Notify designated State staff of all instances of POS downtime greater than ten minutes in length and occurring during regular business hours, within ten minutes of the detection of the downtime. Instances of POS downtime occurring during non-business hours should be reported to designated State staff via e-mail within three hours of the downtime.

5.5.4.16 Maintain a log of all EVS calls and automated inquiries from providers.

5.5.4.17 Provide standard phone line access and performance reports in a State-approved format to the State on a monthly basis for the prior month's activity.

5.5.4.18 Produce a monthly AVR and EVS summary report that includes the following information:

- Total number of calls by method (AVR, POS, web-based, and PC)
- Type of transaction (member eligibility, benefit limits, remittance advice, and PA)
- Inquiry duration
- Inquiry end reason

- Response time
- Totals
- Downtime by mode of verification

5.6 Claims Processing

5.6.1 Overview and Business Objective

The purpose of the Claims Processing function is to ensure that claims, as defined in Glossary of Terms, for eligible members from enrolled providers for covered services are accurately processed and adjudicated in accordance with State and Federal requirements. The Claims Processing business function encompasses the receipt, tracking, and processing of claims through adjudication. Reference, Provider, Member, TPL, and Prior Authorization tables are used in processing claims. High-level processes that support the claims processing business functions are:

- Receive claims and adjustments and assign a unique internal control number (ICN) to each for tracking.
- Return claims to providers for predefined reasons.
- Convert claims to machine-readable format and enter the claims into the system.
- Process claims applying appropriate edits and audits.
- Process claims submitted through electronic claims capture.
- Suspend claims for review when they fail select edits and audits.
- Generate claim correction forms (CCFs) to providers, as appropriate, and monitor their return by providers.
- Adjudicate claims.
- Produce reports to monitor claims processing-related activities.
- Develop claims processing procedures to implement approved IHCP policies

Claims are submitted to the fiscal agent Contractor by providers, VANs, or billing agents in either hard copy or electronic format. Upon receipt by the fiscal agent Contractor, claims are assigned an internal control number for tracking. Paper claims are imaged and data-entered, and electronic claims are loaded into Indiana*AIM* for processing. Claims pass through edits, audits, and pricing logic during processing to adjudication. Claims passing through this logic will be assigned a status of deny, suspend, or ready for payment.

Please note that specific processes and functions related to the processing and adjudication of adjustments and payments are presented in Section 5.7 Financial Management.

5.6.1.1 Business Objective

A variety of reports are produced to support the Claims Processing function.

The objective of the Claims Processing function is to ensure that claims are received, tracked, and processed in an accurate and timely manner.

5.6.2 System Support

The following Indiana*AIM* functions support the processing of claims:

Accepts submission of claims from providers using the appropriate claim type and format

- Accepts electronic transmission of nursing facility, ICF/MR, and hospice rates set by OMPP's rate-setting Contractor
- Provides standardized software to providers for use in entry and transmission of claims data
- Performs logic and consistency editing to screen the claim before acceptance by Indiana*AIM*
- Provides secure file transfer and dial-up facilities
- Performs editing on claims to identify non-covered items based on a table of NDC, UPC, or HRI codes corresponding to the non-covered items; the Contractor shall determine the universe of non-covered codes corresponding to non-covered services based on a State-provided listing of the non-covered items
- Assigns an unique internal control number that includes date of receipt, batch number, and sequence of claim within the batch
- Maintains an image of all paper claims, attachments, and other documents
- Accepts, controls, processes, and reports separately claims for all programs
- Accommodates forms of State-approved electronic media input
- Maintains batch controls and batch audit trails for all claims and other transactions entered into the system
- Maintains an on-line audit trail record with each claim record that shows each stage of processing, the date the claim was entered in each stage, and any error codes posted to the claim at each step in processing
- Supports on-line inquiry to claims from data entry through to payment or denial, including pertinent claim data and claim status with access by member ID, provider ID, and/or internal control number
- Accepts claims via hard-copy or electronic media formats from providers, billing services, Medicare carriers, and intermediaries
- Provides for on-line corrections to suspended claims
- Produces control and audit trail reports during various stages of the claims processing cycle
- Edits each data element of the claim record for required presence, format, consistency, reasonableness, and/or allowable values

- Generates claim correction forms (CCFs) and support on-line updates to claims data when returned with corrections
- Performs automated audit processing using history claims, suspended claims, in-process claims, and same-cycle claims
- Provides, for each error code, a resolution code; an override, force, or deny indicator; and the date that the error was resolved, forced, or denied
- Identifies the allowable reimbursement for claims according to the date-specific pricing data and reimbursement methodologies contained on applicable provider or reference tables for the date of service on the claim
- Deducts recipient spenddown deductible amounts; patient liability; co-payments; and TPL amounts, as appropriate, when pricing claims
- Performs global changes to suspended claims based on State-defined criteria
- Maintains seven years of adjudicated (paid and denied) claims history and all claims for "lifetime procedures" on a current, active claims history file for use in audit processing, on-line inquiry and update, and printed claims inquiries
- Provides a variety of claims reporting functions in State-determined media, including claim detail reporting, recipient and provider history requests, summary screens for claims and related data, and reports necessary to comply with Federal SPR standards and State requirements
- Generates recipient Member Remittance Notices (MRNs).

5.6.3 State Responsibilities

Mail Room

5.6.3.1 Approve document retention and retrieval standards.

Claims Entry

5.6.3.2 Monitor the Contractor through review of claims processing cycle balancing and control reports.

5.6.3.3 Approve all standard, State-specific and modified forms as necessary for the IHCP process in Indiana.

5.6.3.4 Approve the format for electronic media claims.

5.6.3.5 Approve revisions to provider billing manuals.

Electronic Claims Capture

5.6.3.6 Approve policies, guidelines, documentation, and manuals drafted by the Contractor to be furnished to providers.

Pricing and Adjudication

5.6.3.7 Provide written approval of internal and external claims processing procedures that are used to adjudicate claims and control the audit trails and location within the claims processing system.

5.6.3.8 Approve adjudication procedures and processes, including the requirements and procedures for manual pricing of claims.

5.6.3.9 Approve error override policy and procedures for use by the Contractor in claims correction.

5.6.3.10 Approve edit and audit criteria, including edit and audit dispositions.

5.6.3.11 Approve criteria and procedures for adjudication of special claims such as bypass edit and audit conditions.

EPSDT

5.6.3.12 Provide the reimbursement schedule for EPSDT screening providers as needed.

5.6.3.13 Monitor EPSDT program effectiveness using reports produced by the Contractor**.**

5.6.4 Contractor Responsibilities

Mail Room

5.6.4.1 Prepare and control incoming and outgoing IHCP mail, as directed by the State, to ensure claims and other correspondence are picked up at and delivered to any site designated by the State in the most effective and efficient means available.

5.6.4.2 Deliver to the State and other Contractors, and pick up from the State and other contractors, Contractor mail, reports, and other deliveries once in the morning, once in the afternoon each business day, and at the request of the State.

5.6.4.3 Assert positive controls over incoming mail, claims, electronic files and transactions to ensure that all mail, claims, claim attachments, prior authorization materials, adjustment requests, tapes, files, electronic media, and checks are properly processed after receipt by the Contractor.

5.6.4.4 Return hard copy claims missing required data within five business days of receipt. Any attachments must be returned

with the claims. Instructions for the providers on how to correct and resubmit the returned claims must be included when the claims are returned. Process hard-copy attachments to electronic claims. Return attachments that cannot be associated with a claim or other Indiana*AIM* record within five (5) business days.

5.6.4.5 Assign a unique control number upon receipt to every claim, attachment, Claim Correction Form (CCF), and adjustment using the date received in the mailroom within one business day. Attachments must receive the same unique number as the document to which they are attached and remain with it. The Contractor must establish special procedures to ensure attachments remain with the claim document. The Contractor's quality assurance procedures must place special emphasis on ensuring the proper handling of attachments. Image every claim, attachment, accompanying documentation, and ECC transmittal documents within three business days of receipt at the Contractor's site. Process CCFs completed and returned by the provider within ten (10) business days of receipt.

5.6.4.6 Log tapes and other electronic media upon receipt and assign batch number.

5.6.4.7 Batch electronic claims and Encounter Transactions claims upon receipt and assign a unique internal control number.

Claims Entry

5.6.4.8 Perform balancing procedures to ensure control within Indiana*AIM* processing cycles.

5.6.4.9 Produce, reconcile, and submit balancing and control reports that reconcile all claims, including Encounter Transactions, entered into the system to the batch processing cycle input and output counts. The reports shall be provided on a weekly basis the State appointed contact. Include management-level reports to account for all claims and claim types at all times.

5.6.4.10 Maintain data entry keying accuracy standards of 97 percent of items sampled being 100 percent accurate for claims and other transactions. The Contractor shall provide the State with reports documenting compliance and non-compliance with this standard. Provide for key verification of key data elements in accordance with State directives.

5.6.4.11 Load claims submitted electronically by tape, electronic media, and batch transmissions, including Encounter Transactions, within one business day of receipt by the Contractor.

5.6.4.12 Perform required presence and validity editing on entered claims and Encounter Transactions according to State specifications.

5.6.4.13 Perform validity editing on entered claims and Encounter Transactions against provider, member and reference data.

5.6.4.14 Generate and submit claims entry statistics reports in a format conducive to assessing performance compliance.

5.6.4.15 Retain hard-copy documents and claims in accordance with State-mandated record retention regulations.

5.6.4.16 Retrieve claim and other documentation requested by the State within three business days of receiving the request**.**

Electronic Claims Capture

5.6.4.17 Maintain an ECC system to allow electronic submission of claims from providers using the software, hardware, and telecommunications facilities of the automated eligibility inquiry system.

5.6.4.18 Provide appropriate staff to support both technical and informational aspects of ECC.

5.6.4.19 Provide necessary electronic data interchange (EDI) capability to providers, including troubleshooting assistance, free of charge. Allow EDI submitters to submit test transactions. Report the results of such testing to the submitter. Assist EDI submitters in testing their billing via electronic submissions without charge.

5.6.4.20 Perform necessary logic and consistency editing for submitted claim data.

5.6.4.21 Provide on-line response notification and billing error notification to providers and MCOs submitting batch claims transactions within five minutes of receipt of incoming claim transactions.

5.6.4.22 Maintain standard claim control and tracking standards for claims submitted by ECC.

5.6.4.23 Produce ECC claim submissions reports.

5.6.4.24 Update the claims entry files daily ECC-submitted claims.

Pricing and Adjudication

5.6.4.25 Perform claims adjudication based on State-approved rules for date of service and date of adjudication.

5.6.4.26 Ensure the reference subsystem meets State-approved prepayment and medical review criteria.

5.6.4.27 Process special claims and batches through adjudication according to State policy or instructions within ten (10) business days of receipt of the special batch request.

5.6.4.28 Provide to the State a detailed report on all special batches including but not limited to special batch reasons, processing timeframes, and return reasons for special batches returned to the requestor.

5.6.4.29 Maintain sufficient staff to resolve claims that suspend and to manually adjudicate claims according to State-specified criteria.

5.6.4.30 Price claims in accordance with IHCP policy, benefits, and limitations as defined by the State.

5.6.4.31 Process Encounter Transactions received from MCOs via electronic media.

5.6.4.32 Maintain a method to process for payment any specific claim(s), as directed by the State, on an exception basis and maintain an audit trail.

5.6.4.33 Image with date and time all Claim Correction Forms (CCFs) received from providers to ensure that they can be tracked to a specific claim. Ensure CCFs are processed in a timely manner. Track CCFs returned by providers after the due date.

5.6.4.34 Manually and systematically review and resolve claims that suspend for edits and audits as determined by the State.

5.6.4.35 Monitor the use of override codes by Contractor staff during the claims resolution process to identify potential abuse, based on State-defined guidelines.

5.6.4.36 Maintain pricing summary reference material that is up to date, comprehensive, and sufficient to allow for proper pricing of all manually priced claims (for example certain medical supplies and Durable Medical Equipment (DME)).

5.6.4.37 Edit, audit, and adjudicate claims each business day. Adjudicate all web-based claims within one (1) business day.

5.6.4.38 Update claims data with Claims Correction Form (CCF) responses or paper attachments received for electronic claims within five business days of receipt.

5.6.4.39 Pay, deny, or suspend paper claims within 30 calendar days of receipt by the Contractor.

5.6.4.40 Pay, deny, or suspend electronically submitted claims within fourteen (14) calendar days of receipt by the Contractor.

5.6.4.41 Calculate interest on electronically submitted clean claims (according to IC 12-15-13 as amended by P.L. 107-1996) not paid or denied within 21 calendar days of receipt, beginning on the 22nd day after receipt and accruing until the date the claim is paid. The interest rate shall be specified by the State and calculated on the IHCP paid amount.

5.6.4.42 Calculate interest on clean paper claims (according to IC 12-15-13 as amended by P.L. 107-1996) not paid or denied within 30 calendar days of receipt, beginning on the 31st day after receipt and accruing until the date the claim is paid. The interest rate shall be specified by the State and calculated on the IHCP paid amount.

5.6.4.43 All claims (clean and unclean) shall be adjudicated (paid or denied) within 90 calendar days of receipt.

5.6.4.44 If a claim fails an edit or audit that is workable by the Contractor in addition to an edit or audit that must be worked by the State or another contractor, the Contractor will have up to 30 calendar days from the receipt of the claim to resolve the edits and audits that are workable. The Contractor shall provide the State or other contractors with copies of the claims and all attachments for those claims that have suspended for their work no later than ten (10) business days from the ICN date on the suspended claims. The Contractor may employ a work flow system that allows such claims to be worked simultaneously, as long as it provides for controlled adjudication of the claim.

5.6.4.45 Ensure that the date that a claim is paid is the date of the check or EFT payment.

5.6.4.46 Reprocess erroneously denied claims within 10 business days of discovery of erroneous denial. The Contractor shall establish and maintain a process to accept phone and written requests to reprocess erroneously denied claims. The Contractor shall establish a tracking method demonstrating compliance with this requirement, and provide the detailed information to the State.

5.6.4.47 Select a statistically valid random sample of different claim types in various statuses on a monthly basis, and perform a quality control check on the claims to ensure accurate processing, including editing, auditing, and pricing.

5.6.4.48 Handle administrative review requests in accordance with timeframes established by the State for claims and support the claim appeals process.

EPSDT

5.6.4.49 Identify and report claims for non-covered IHCP services provided to members younger than 21 years of age. Prepare the report monthly in a format to be approved by the State.

5.6.4.50 Document, in accordance with Federal and State EPSDT reporting requirements, screening services provided, and required referrals made.

5.6.4.51 Report diagnoses submitted on claim forms.

5.6.4.52 Identify and report, from paid claims, members receiving treatment under the EPSDT program.

5.6.4.53 Generate EPSDT program management reports containing recipient-level and summary data utilizing data from fee-for-service and Encounter Transactions. These reports include costs relating to EPSDT services**.**

Claims Reporting

5.6.4.54 Generate and distribute Member Remittance Notices (MRNs) to allow recipients to report services that they did not receive or that were inaccurately billed. Distribute the MRNs within two business days after the end of the claim processing month. The Contractor shall distribute MRNs to a percentage of population specified by the State. The State is currently

generating MRNs to one percent of the total enrolled population on a monthly basis.

5.6.4.55 Deliver returned MRNs to the State or State-designated Contractor for review. The MRNs shall contain a return address as designated by the State.

5.6.4.56 Provide on-line inquiry access to active and permanent claims history files and the status of suspended claims.

5.6.4.57 Upon request provide the State with hard-copy original claims, adjustments, attachments, CCFs, non-claim transaction documents, ECC billings, and Encounter Transactions claims for all transactions processed.

5.6.4.58 Provide training to State staff in the use of the claim processing system on an ongoing basis, as requested by the State.

5.6.4.59 Generate and submit claims inventory and operations reports after each claims processing cycle.

5.6.4.60 Calculate and report on a monthly basis to the State the Encounter Transaction submittal error rates as compared to MCO standards for Encounter Transaction standards.

5.6.4.61 Implement a quality assurance program to review claims processed through the system, to ensure claims entry, claims resolution, and claims adjudication activities are performed in accordance with approved guidelines. Report on the quality of claims processing monthly. Review the report and take actions to improve the process, and increase efficiency and accuracy.

5.6.4.62 Make available within one business day of receipt, State and other entities as requested by the State requests for member and provider history printouts from the intranet. Deliver history printouts within five business days of receipt of the request**.**

Coordination Activities

5.6.4.63 As directed by the state, develop and maintain coordination methods, including interfaces and extracts to other entities.

5.6.4.64 Forward to the TPL Unit designated by the State copies of claims and associated attachments for claims that have suspended or contain TPL information but no TPL information exists on file or conflicts with the information on file. Forward all such materials within three (3) business days of discovery.

5.6.4.65 Provide the State or designated Contractor with claims information needed to perform the drug rebate function and resolve disputes. Provide claims data to companies that make utilization data available to manufacturers as directed by the State.

5.6.4.66 Provide claims information contractors as requested by the State.

5.6.4.67 Accept PA information entered by the PA Contractor into Indiana*AIM*.

5.6.4.68 Provide claims extracts to contractors for utilization reviews as specified by the State.

5.6.4.69 Work with the TPL Unit to resolve claims payment issues related to TPL.

5.6.4.70 Provide necessary research and documentation in preparation for appeals or court actions. Give testimony as needed.

5.6.4.71 Integrate adjudicated pharmacy claims data into the claims history and weekly financial files for provider payment.

5.6.4.72 Generate weekly pharmacy remittance advice statements, EFT transfers and checks for adjudicated claims.

5.6.4.73 License and use Captiva or other imaging and Optical Character Recognition (OCR) software approved by the State to image claims and other documents and extract data from paper documents and convert to data files.

5.7 Financial Management

5.7.1 Overview and Business Objective

The Financial Management function ensures that State funds are appropriately disbursed for the payment of claims and such that post payment and federal transactions are applied accurately. Financial activities include claim payment processing, adjustment processing, and other financial transactions.

Financial procedures use the output of claims processing adjudication. Financial processing produces the detailed information used for provider checks, remittance statements, and financial reports.

The Financial Management business functions are critical components of Indiana*AIM*. All financial activities and processes must be performed

accurately and expeditiously and in accordance with Federal and State requirements.

5.7.1.1 Payment Processing

The payment process uses adjudicated claims, including adjustments, and other financial transactions to calculate the provider's earnings for each payment cycle. Provider 1099 earnings information is updated weekly, and remittance advice (RA) statements are generated for providers with claim or financial transaction activity. RAs contain paid, denied, and suspended claims as well as other financial transaction information.

After checks are printed, voided check numbers are entered online through a check screen. Check information is contained on a check register report and a tape used for bank reconciliation. Providers participating in the electronic funds transfer (EFT) program will have their payments electronically transferred to their banks.

Annual 1099 reports containing provider earnings information are processed at the end of the calendar year to prepare the 1099 tape for the Federal government.

5.7.1.2 Adjustment Processing

Adjustment requests are received, logged, and imaged in the mailroom. Adjustment requests are researched and entered on-line.

In the single claim adjustment process, one specific claim is reviewed upon request from the provider, State, or Contractor. Updates to the claim are entered online, and an updated version of the claim is produced. The adjusted claim is processed through the edit and audit processing and claims pricing functions. If the repriced payment amount is greater than the recouped amount, the provider receives payment for the difference. If the adjusted claim pays less than the original claim, the difference is offset against the provider's claim payment for that week or an accounts receivable is established to offset future claims payments.

The mass adjustment process adjusts a group of claims based on selection criteria, which may include time period, provider number, member number, service code, or claim type. Mass adjustments are created to reprice claims. Selection parameters are entered online, and paid claims matching the criteria are displayed. Claims are processed, and appropriate payment and

recoupment is made to each provider whose claims were affected by the mass adjustment.

5.7.1.3 Other Financial Processing

Financial transactions such as check voids, check reissues, stale-dating checks, returned checks, stop payments on checks, manual checks, cash receipts, repayments, accounts receivable, non-claim-related system payments (payouts), and recoupments are processed as part of the financial management function. Online screens are available to enter financial transaction data, and the system establishes the appropriate credits or debits to the appropriate account. Account ledger screens are available for inquiry.

Accounts receivables are established when the State is due money from providers, insurers and other third-party carriers. For each case in which a provider owes money to the State, an accounts receivable for that provider is created. Under Indiana statute, simple interest may be assessed on select accounts receivable per State directions. When funds are collected from the providers in full or partial settlement of the indebtedness, the recovery amounts are first applied to the accumulated interest and then to the principal amount of the indebtedness. The Contractor is required to collect funds due the State from providers either through cash payments or through offsets to payments due to the providers.

5.7.1.4 Business Objective

The objectives of the Financial Management function are as follows:

- Operate the Financial Management system in accordance with generally accepted accounting principles (GAAP).
- Ensure that funds are appropriately disbursed.
- Produce accurate and timely provider payments, remittance statements, and financial reports.
- Perform automated single and mass adjustments using online request screens.
- Process non-claim-specific financial transactions such as provider payments, recoupments, and liens.
- Collect the money due to the State in an expedited manner.

5.7.2 System Support

Indiana*AIM* contains the following features to support Financial Management functions:

- Maintains payment mechanisms to providers, including check generation and Electronic Funds Transfer (EFT).
- Maintains provider accounts receivable and deducts appropriate amounts from payments due the provider
- Generates provider RAs in electronic or hard-copy media
- Maintains sufficient controls to track each financial transaction, balance batches, and maintain appropriate audit trails on the claims history file
- Generates provider 1099 reports annually, which indicate the total paid claims minus any recoupments or credits
- Maintains an interface with FSSA or the State Budget Agency to transmit financial data
- Tracks all financial transactions, by source, including fraud and abuse recoveries, provider payments, etc

5.7.3 State Responsibilities

5.7.3.1 Review inventory management, other operational claims reports, and financial reports from the Contractor.

5.7.3.2 Any checks received by the State will be deposited by the State. If the check is a provider receivable then copies can be delivered to the Contractor.

5.7.3.3 Monitor weekly payments to providers.

5.7.3.4 Approve financial processing and adjustment processing policies and procedures.

5.7.3.5 The State will fund a zero balance bank account to cover provider claims. The Contractor will issue all provider payments.

5.7.3.6 Review verbal notifications and written reports of inappropriate payments to decide whether future research and analysis is required, determine if a correction plan is required, review and approve the plan for correction, and establish a correction date.

5.7.3.7 Monitor all of the Contractor's financial management activities and processes to ensure compliance with program requirements.

5.7.3.8 Monitor the Contractor's provider accounts receivable to verify that credit balances are appropriately cleared.

5.7.3.9 Review and approve partial payments and repayment agreements

5.7.3.10 Provide the Contractor with approved policies regarding partial payments and repayment agreements**.**

5.7.4 Contractor Responsibilities

5.7.4.1 Operate the Indiana*AIM* financial management functions effectively, efficiently, and in compliance with all the performance standards in this contract and with applicable State and Federal policy, law, and regulation. This includes developing and monitoring written procedures which address accounts receivable balance notification, collection procedures, and interest calculation as directed by the State. Provide and maintain staff knowledgeable in policy and procedures as they pertain to the financial management requirements of the IHCP program.

5.7.4.2 Produce and maintain comprehensive, accurate written procedures documenting all aspects of the financial management system and procedures followed by Contractor staff and management.

5.7.4.3 Provide and execute quality assurance procedures and performance standards to ensure that the financial management system disburses, tracks, and accounts for IHCP payments and accounts receivables accurately and timely.

5.7.4.4 Provide a high level of customer service to the program stakeholders who interface with and rely on information, reports, and processes of the financial management system.

5.7.4.5 Provide claims payment data to the State.

5.7.4.6 Produce provider payments in hard-copy check format or through electronic funds transfer.

5.7.4.7 Deposit checks into the Contractor's bank account within 24 hours of receipt or the next business day**.**

5.7.4.8 Log and enter check information into the check disposition screen for assignment of a Cash Control Number (CCN) within one (1) business day.

5.7.4.9 Disposition checks against accounts receivable, and update accounts accordingly within ten (10) business days of receipt.

5.7.4.10 Review financial reports on a daily basis and perform research and resolution activities for non-dispositioned checks that are the responsibility of the Contractor. Correctly disposition the check upon completion of the research.

5.7.4.11 Produce weekly remittance advices (hard copy, HIPAA X12 transactions, and electronic as approved by the State), combine advices with checks and CCFs where appropriate, and transmit or deliver to the correct providers.

5.7.4.12 Present information on the RA in a non-technical language that is understandable to providers.

5.7.4.13 Perform at least one payment cycle weekly on a schedule approved by the State.

5.7.4.14 Produce and send the EFT register to the State on the schedule mandated by the State (currently by 11:00 a.m. on the Monday following the weekly payment cycle).

5.7.4.15 Send signed, original claim vouchers and invoices for each program after completion of the financial cycle.

5.7.4.16 Provide and maintain cash management techniques (such as zero-balance bank accounts), and produce reports that meet the requirements of the Cash Management Improvement Act of 1990. The Contractor shall maintain a zero-balance bank account. At a minimum, the Contractor must:

- Deliver a daily request for funding to the state on the schedule mandated by the State (currently by 10 a.m. each business day).
- Provide an estimate of checks to be presented by 10 a.m. of the business morning preceding a State holiday

5.7.4.17 Produce reports necessary for the State to monitor the daily balances of the Contractor's provider payment account.

5.7.4.18 Operate the financial functions to be fully compliant with appropriate 1099 and backup withholding regulations. This includes:

- Produce and mail (or transmit electronically to some providers) provider 1099 earnings reports in accordance with federal and state regulations no later than January 31 of each year.
- Research and respond to Federal and provider inquiries concerning 1099 information
- Produce B-notices and other notices on the schedule required by the IRS. Pay any penalties for failure to meet IRS requirements without charge to the State.
- Notifying the State via the daily funding process of any backup withholding dollars transmitted to the IRS

5.7.4.19 Perform adjustments to original and adjusted claims and maintain records of the previous processing.

5.7.4.20 Execute and perform mass adjustment processing and claim reprocessing within ten (10) business days of receipt of the request or on the schedule agreed to by the State. This includes mass adjustments, liens, and non-claim-specific returns.

5.7.4.21 Execute and perform retroactive adjustment processing within ten business days of receipt of the request from the rate-setting Contractor or LTC rate change notice.

5.7.4.22 Review and adjudicate ninety 90 percent of all non-check provider requests for adjustments within 30 calendar days of receipt. The remaining ten percent of non-check-related adjustments and 100 percent of check-related adjustments must be adjudicated within 45 calendar days of receipt. The Contractor shall provide the State with reports to monitor compliance.

5.7.4.23 Process void / replacement claims and Encounter Transactions electronically and update history.

5.7.4.24 Maintain a system of security and monitoring for the location and disposition status of provider-returned checks and provider checks.

5.7.4.25 Update claim history and online financial files with the check number, date of payment, and amount paid after the claims payment cycle.

5.7.4.26 Develop, implement, follow, and update internal receivable collection procedures approved by the State and documented in the current Contractor's operating procedures manual or as specified by the State. Make recommendations to the OMPP on ways to improve the overall financial management of the IHCP, including A/R collection improvements, CMS-64 reporting, etc. Provide control charts to graph CMS-64 quarterly variances and provide charts along with variance explanations to OMPP within 15 business days of the first quarter of each month. Develop and implement procedures to resolve all discrepancies between the CMS 64 report and actual data.

5.7.4.27 Monitor the status of each accounts receivable and report monthly to the State in aggregate and/or individual accounts. Contractor must produce system and manual reports as detailed

in the operating procedure manual or as currently in use that allows the state to fully monitor the status of accounts receivable.

5.7.4.28 Produce provider payment accounts receivable balance reports after each weekly financial cycle and submit to the State.

5.7.4.29 Assess and collect interest on select accounts receivable in the time frame specified by the State.

5.7.4.30 Complete all good faith collection effort within 60 calendar days from the date of discovery or in accordance with a State-approved repayment agreement. Accounts receivables that are not collected within 15 business days receive a demand or transfer letter or phone call at a minimum, unless it is clear the accounts receivable will be collected systematically in the next financial cycle. Follow, at a minimum, the contact and collection efforts that are either set out in the operating procedure manual or in operant practice, as directed by the State. All reasonable efforts to collect from and locate the providers must be accomplished before referring the provider to the Attorney General's office for further action. Referrals must be made in accordance with the current format and documentation requirements. Routinely check with the Secretary of State's office to determine if the provider corporation entity has been dissolved. Refer uncollectible accounts receivable balances to the State, for submission to the Attorney General's office in accordance with the operating procedure manual and current operant practices. Referrals to the Attorney General's office must occur by no later than 90 days following the establishment of the accounts receivable for those providers that have not satisfied any portion of the accounts receivable. Refer uncollectible accounts receivable balances to the State in accordance with the operating procedure manual.

5.7.4.31 Generate reports, and appropriate back-up documentation, for the State's use in reclaiming FFP (on the CMS-64) in those instances in which previously returned FFP on uncollectible accounts receivable become eligible for repayment to the state.

5.7.4.32 Fully comply with the provisions set out in 42 CFR Subpart F. Utilize existing procedures (recommending enhancements, as appropriate) to maximize recovery efforts from providers. Determine and document all refund and reclaim provisions set out in this subpart. Exercise initiative in ensuring complete compliance with the subpart.

5.7.4.33 Prepare complaints, in accordance with guidelines established by the Attorney General's office, for those providers meeting the criteria for same.

5.7.4.34 Provide online access to financial information.

5.7.4.35 Make disproportionate share hospital (DSH) payments, as directed by the State.

5.7.4.36 Make Medicaid payments in lieu of Hospital Care for the Indigent (HCI) payments, as directed by the State.

5.7.4.37 Apply Medicaid Upper Payment Limits payments as directed by the State

5.7.4.38 Update and withhold monthly nursing facility Quality Assessment Fees (QAF), as well as ICF/MR and CRF/DD assessment amounts as provided by the State. Generate detailed monthly reports containing monthly assessment activity, including provider assessments made during the month, adjustments made to prior months' activities and outstanding balances due on assessments partially withheld. Provide the State with a monthly accounting of the assessment amounts. Perform reconciliations activities as a result of changes in the monthly assessment fees from the rate-setting Contractor within thirty (30) calendar days of receipt of the information.

5.7.4.39 Prepare and submit a report to the State separately listing all Contractor-or State-identified inappropriate and/or incorrect payments.

5.7.4.40 Process IRS and court order liens and garnishments within three business days of receipt or in accordance with the IRS or court documents, whichever is earlier

5.7.4.41 Review financial information for providers for whom bankruptcy notices are received either directly or as referred by the State to determine whether any outstanding accounts receivables exist; check with other Medicaid contactors to determine if the provider owes money to the program; complete a proof of claim form (B10) and submit to FSSA within 3 business days of receipt, or sooner if the filing date expires before the end of the 3-day completion period. Maintain an electronic log of all bankruptcy cases. Log must be available to FSSA staff. Check on the status of bankruptcy cases in accordance with FSSA's review schedule and take

appropriate follow-up action as the status may change. Follow policy as outlined in State-approved procedures.

5.7.4.42 Generate demand letters to providers with accounts receivables aged greater than 15 business days each Monday and research each provider to determine if a) demand letter has previously been sent b) accounts receivable can be transferred or c) demand letter should be sent. Letters must be mailed within three business days of generation as determined by research.

5.7.4.43 All initial demand and transfer letters are sent via certified mail. Providers are called within five business days of the return of the certified mail receipt if provider has not responded to the demand or transfer letter. All letters and phone calls are tracked in letter and phone logs.

5.7.4.44 All phone calls received from providers regarding accounts receivables are returned within two business days. All Contractor-initiated phone calls to providers will be followed up within three business days if first attempt to reach provider via phone was unsuccessful**.**

Coordination Activities

5.7.4.45 Work with other state contractors to define appropriate CCN batch ranges, and establish the agreed-upon batch ranges to support the disposition of checks received in support of other business functions.

5.7.4.46 Work with other State contractors to develop procedures and protocols if a check is received by one of the other contractors but is the responsibility of the Contractor.

5.7.4.47 Arrange with the Contractor's bank to accept nightly transfers from the other contractors' banks.

5.7.4.48 Work with the other State contractors to establish procedures to address cases in which a provider sends a check to another State contractor and a claim needs to be adjusted

5.7.4.49 Coordinate refund and non-claim payment activities with the other contractors as necessary, when excess monies or payments have been received or non-claims specific expenditures are required. The Contractor shall be responsible for sending the refund(s) or non-claim specific payment to the appropriate entity.

5.7.4.50 Maintain secure storage of paper check stock, signature devices, and printing facilities to assure that no single person can issue Medicaid checks.

5.7.4.51 Verify receipt and transmission of all financial files to and from the bank.

5.7.4.52 Provide the capability to analyze checks and EFTs before they are released. At the state's direction, pull check and EFT transactions and void associated claims. Perform an analysis each week and present a report of suspicious checks to the State for review before checks and EFTs are released.

5.8 Medicare Buy-In

5.8.1 Overview and Business Objective

The Buy-In business function supports the State purchase of insurance premiums for IHCP members eligible for Medicare Part A (hospital) and Part B (medical). Payment of premiums for these members allows the State to share the costs of members' medical care with Medicare.

To be eligible for Buy-In, members are required to meet the eligibility criteria in the Indiana State Plan.

Initially, Medicare Buy-In eligibility data is gathered by county caseworkers and is entered into ICES. ICES interfaces with Indiana*AIM* daily to update member database tables. When the information has been transmitted from ICES, Indiana*AIM* automatically determines the Buy-In effective dates.

Monthly automated data exchanges are conducted between Indiana*AIM*, the Social Security Administration (SSA), and CMS. Information is exchanged in order to identify, update, and resolve differences and to monitor new and ongoing Buy-In cases. Indiana*AIM* interfaces monthly with CMS to coordinate the Buy-In premium billing file exchange. At times, manual adjustments are initiated to resolve problems preventing member Buy-In.

Monthly premium payments are made to CMS by the State's Finance Division once the premium billings have been received. Payments are tracked and reported to CMS for FFP reimbursement using information from Indiana*AIM*.

5.8.1.1 Business Objective

The State's objective for the Buy-In business function is to pay premiums for eligible member in order to reduce the costs of services to the IHCP

5.8.2 System Support

Indiana*AIM*'s automated features supporting this function include the following elements:

- Creates the Medicare Part B file (referred to as the Premium 150 Sending File) for submission to CMS
- Creates the Medicare Part A file (referred to as the Premium S15 Sending File) for submission to CMS
- Creates the Medicare Part D file for submission to CMS
- Generates letters to CMS regarding issues related to the Buy-In business function

Generates reports to support the Buy-In business function State Responsibilities

5.8.3 State Responsibilities

5.8.3.1 Monitor the Contractor's Buy-in activities

5.8.3.2 Ensure that the DFR provides proper data for Indiana*AIM* Buy-In Part A, Part B, and Part D master files to ensure that Buy-In for eligible members can be accomplished.

5.8.3.3 Review and approve all Buy-In forms and letters used for the accretion of eligible IHCP members to Buy-In Part A, Part B, and Part D.

5.8.3.4 Approve all updates to the FSSA and Contractor internal standard Buy-In procedures manual.

5.8.4 Contractor Responsibilities

5.8.4.1 Perform all automated and manual processes for Medicare Buy-In activities, including identification of potentially eligible individuals (for example, members older than 65 years old who do not have Medicare on file), data exchange, and premium payments.

5.8.4.2 Create the Medicare Part A, Part B and Part D billing files, and transmit to CMS no later than the 25th of the month in accordance with the State Buy-In Manual.

5.8.4.3 Notify the State of problems with the data exchanges and the accuracy of Part A, Part B and Part D Buy-In processing and reports within two business days of problem identification.

5.8.4.4 Communicate with ICES to ensure proper exchange of data between ICES and Indiana*AIM* to carry out the Buy-In and Part D programs.

5.8.4.5 Appoint a professional-level liaison to work with CMS, SSA, and the State's Data Mover staff to ensure that reliable data exchanges and file updates occur in a timely manner in accordance with the State's Buy-In manual. Identify, and inform the State of, problems with the data exchanges as they arise and coordinate the solutions with the State.

5.8.4.6 Monitor the State's receipt of Buy-In billing files and Part D files transmitted to the State over the Network Data Mover.

5.8.4.7 Coordinate system changes as necessary to maintain an accurate data exchange and to implement new Federal and State regulations, as necessary.

5.8.4.8 Resolve individual Buy-In and Part D case problems in an accurate and timely manner.

5.8.4.9 Request State reimbursement from CMS and ensure that any premiums paid to CMS in error are reimbursed to the State, in accordance with the State Buy-In Manual.

5.8.4.10 Distribute a copy of the Buy-In billing invoice (transmitted from CMS via the Network Data Mover) to Financial Management on a monthly basis.

5.8.4.11 Communicate with the State designated contacts via telephone, ICES mail or e-mail, or fax requesting updates to ICES as needed to ensure accretion to Buy-In for all eligible members

5.8.4.12 Track and report to the State the number of Buy-In mismatches on a monthly basis. This information should also be presented over time to illustrate trends. The report must be accompanied by a qualitative and quantitative analysis performed by the Contractor.

5.8.4.13 Oversee the accuracy, distribution, and timeliness of both the Part A, Part B and Part D Buy-In reports, identifying any problems as they arise, communicating them to the State, and recommending options and viable solutions for State review and approval.

5.8.4.14 Provide a management report on a monthly basis that includes a monthly status of the Medicare Part A, Part B and Part D exchange in a format approved by the State.

5.8.4.15 Monthly, provide a Buy-In activity report that includes a summary of issues and trending analysis comparing the performance of Buy-In activities for previous months, the status of cases resolved, and other activities that have occurred during the month.

5.8.4.16 Provide accurate and thorough written responses to Buy-In and Part D inquiries, as directed by the State. The Contractor must provide the requesting party an acknowledgment, within two business days of receipt of the request, including an estimate of how long it will take to answer the question or to provide the requested information. Responses to inquiries from government officials shall be provided within three business days of receipt of the request. All other inquiries shall be responded to within ten business days of receipt of the request.

5.8.4.17 Update, print, and distribute the Buy-In Operations Procedures Manual, in accordance with State instructions, as needed.

5.8.4.18 Monthly, update the eligibility and the Part A, Part B and Part D records received from the CMS Buy-In Part A, Part B and Part D billing files.

5.8.4.19 Produce and submit to the State or CMS accurate and timely Buy-In and Part D reports and data files, in accordance with State specifications.

5.8.4.20 Reconcile Buy-In accretes and deletes transactions in error monthly.

5.8.4.21 Notify State-mandated contacts when the contact should initiate member enrollment in Buy-In.

5.8.4.22 Identify and suggest to the State any improvements that could be made to improve the quality of data and the timeliness of processing.

5.8.4.23 Coordinate with State designated contacts to research issues related to Buy-In members.

5.8.4.24 Maintain qualified personnel to respond to Buy-In questions from members and caseworkers.

5.8.4.25 On an ongoing basis, proactively propose and provide recommendations for potential changes to the Buy-In business function to enhance effectiveness.

5.8.4.26 Develop, modify, and maintain procedures to resolve issues regarding the Buy-In business function. Procedures shall be approved by the State.

5.8.4.27 Produce and distribute the Medicare Buy-In recruitment letters quarterly.

5.8.4.28 Create interfaces and procedures to receive, process and use Medicare Enrollment Database (EDB) files at least monthly as available from the Centers for Medicare and Medicaid Services (CMS).

5.8.4.29 Post date of death from State sources, and assure that no buy-in premiums are paid for periods after the date of death.

Coordination Activities

5.8.4.30 Coordinate with the TPL Unit related to Buy-In issues

5.9 Managed Care Support

5.9.1 Overview and Business Objective

The State of Indiana has several managed care programs designed for various populations within the Indiana Health Care Programs (IHCP). Enrollment in managed care is mandatory for the following:

- Members who are eligible for TANF cash assistance and pregnant women and children at or just above the Federal poverty level
- Children's Health Insurance Program (CHIP)
- Aged, Blind, and Disabled: The following IHCP populations are currently excluded from the managed care programs:
  - Those who are institutionalized
  - Those who must spend down their income and/or resources to be eligible for IHCP
  - Those who are receiving services under a home and community-based services (HCBS) waiver

PMPs offer a medical home for their assigned members, providing and/or authorizing all primary, preventive, and most specialty care for members assigned to their panels. Medical services are delivered in one of two delivery models:

- Primary Care Case Management (PCCM) in which PMPs are reimbursed on a fee-for-service basis. Additionally, PMPs in PCCM receive a

monthly per member per month administrative fee payment to compensate them for the overall coordination of medical care to their members. Members enrolled may access the provider of their choice for some services called self-referral services.

- Risk based managed care (RBMC) in which providers are reimbursed through an arrangement with a managed care organization (MCO) that receives a monthly per member per month capitation fee for provision of services. Members must obtain most services from the network of providers in the MCO in which they are enrolled. Members enrolled in an MCO may access the provider of their choice for some services called self-referral services. However, the MCO is responsible for reimbursing self-referral services providers, including those that are not in the MCO's network. Additionally, some services provided to MCO members are not included in the capitation paid to the MCO and are reimbursed by the fiscal agent on a fee-for-service basis. The State will set rules for enrollment into the various managed care options.

The OMPP administers the IHCP Managed Care program with the assistance of several contractors:

- An enrollment broker and a PCCM Administrator is responsible for recruiting providers for the PCCM program, member education and choice counseling, enrolling and disenrolling members, maintaining a toll-free help line and performing quality improvement activities.
- A managed care contract monitoring Contractor is responsible for performing readiness reviews and external quality review studies to meet CMS requirements as well as ongoing contract monitoring and review activities.
- An actuary assists the State in determining the capitation rates paid to the MCOs and demonstrating the cost effectiveness of the waiver program for CMS.
- Managed Care Organizations are responsible for arranging for medical care in accordance with their contractual arrangements with the State.
- The Contractor is responsible for functions that include acceptance and processing of Encounter Transactions; payment of administrative and capitation fees; tracking, maintenance, and processing of managed care provider and member enrollments, disenrollments, and changes; performing the auto-assignment process; production of rosters and reports; and preparing for monthly policy meetings. Contractor responsibilities for these meetings include, but are not limited to, preparing the agenda for the OMPP's approval, providing minutes, and notifying members of meetings. Other contractors are individually responsible for assisting the State in capitation rate-setting, external quality review, waiver evaluation, and provision of medical services.

5.9.1.1 Business Objective

The goals of the IHCP Managed Care program are to:

- Ensure access to primary and preventive care
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

The objectives for the managed care support function of this contract are to assist the State with working toward these goals. The Contractor assists with this function through such means as maintaining provider and member managed care enrollment information and history, performing an auto-assignment process correctly and appropriately, reimbursing managed care organizations correctly and appropriately, maintaining capitation rate information, and maintaining and reporting on Encounter Transactions and managed care data in order to evaluate the effectiveness of the program in working toward its goals.

5.9.2 System Support

The automated features of Indiana*AIM* that currently support this business function include:

- Processing eligible members through auto-assignment to appropriate PMPs enrolled in the IHCP Managed Care program.
- Payment of monthly capitation rates and administrative fees.
- Production of enrollment rosters for MCO and PCCM PMPs
- Generation of letters to members notifying them of managed care enrollment status.
- Generation of letters to PMPs notifying them of member enrollments and managed care enrollment status.
- Generation of monthly lists of PMPs participating in the networks.
- Generation of semi-monthly list of specialists, facilities, and ancillary providers in the networks.
- Generation of quarterly authorization codes for PMPs in the PCCM delivery system.
- Processing and reporting of Encounter Transaction data to OMPP and MCOs.
- Preparation of monthly MCO Encounter Transactions compliance reports.
- Payment of MCO's appropriate capitation rates for appropriate people.
- Generation of various reports to support the IHCP Managed Care managed care program.

- Maintenance of IHCP Managed Care provider information, including managed care enrollment history.
- Maintenance of IHCP Managed Care recipient information, including managed care enrollment history.
- Maintenance and update of capitation rates and rate cells, as appropriate.

5.9.3 State Responsibilities

5.9.3.1 Review and approve Contractor-developed plans, policies, and procedures for administering the Indiana managed care programs.

5.9.3.2 Review and approve enrollment forms and contractual arrangements for provision of managed care services.

5.9.3.3 Monitor managed care activities and meet with Contractor staff regularly to provide direction and focus for Contractor activities.

5.9.3.4 Promulgate regulations, as necessary, to establish policies for managed care programs.

5.9.3.5 Review and approve the methodology for assigning MCO capitation rates to enrolled members; validate that the correct capitation rate for each rate cell for each MCO is correctly loaded into the system.

5.9.3.6 Participate in monthly managed care policy meetings and attend other meeting, as required.

5.9.3.7 Review and approve recipient disenrollments, received through the enrollment broker, PCCM administrator, or from IHCP Managed Care

5.9.4 Contractor Responsibilities

Ge**n**eral Program Support

5.9.4.1 Provide support to the Indiana managed care programs in accordance with the Contractor responsibilities defined in the Managed Care Operating Procedures Manual, the Managed Care Organizations' Policy and Procedures Manual and other managed care program manuals.

5.9.4.2 Provide and maintain staff knowledgeable in policy and procedures as they pertain to the managed care requirements of the IHCP.

5.9.4.3 Provide a high level of customer service to the program stakeholders who interface with and rely on information and reports generated by Indiana*AIM*.

5.9.4.4 Assist the State to develop detailed plans, policies, and procedures for implementing and administering managed care programs.

5.9.4.5 At least every six months, prepare, produce, make available, and update the Managed Care Organization's Policy/Procedure Manual and Managed Care Operating Procedures Manual (as approved by the State) for managed care programs for use by Contractor staff, MCOs, other managed care contractors, and State staff. This includes incorporating newly adopted policies and changes to policies

5.9.4.6 Meet regularly with State staff and other managed care contractors, including MCOs, regarding managed care objectives, policy and technical issues. The Contractor shall be responsible for coordinating the meetings, distributing an agenda prior to each scheduled meeting, and recording and distributing meeting minutes for all managed care policy and technical meetings.

5.9.4.7 Conduct provider education and support on managed care related programs and issues.

Data Analysis and Reporting

5.9.4.8 Monthly or upon request, provide the State with enrollment and disenrollment statistics regarding recipients and providers participating in the IHCP Managed Care program to evaluate program effectiveness.

5.9.4.9 Provide quality assurance procedures to ensure that Indiana*AIM* produces information, data, and reports accurately, on time, and in a format that is easily understood.

5.9.4.10 Conduct research and data analysis on managed care issues at the direction of the State. Report to the State in writing on the results of that research in a time frame mutually agreed to by the Contractor and the State.

5.9.4.11 Assist the OMPP or its designated Contractor to develop provider profiles, identify trends in use, and forecast future use of services.

5.9.4.12 Provide the State, or its designated Contractor, with the results of the Fiscal Agent and Related Services Contractor's ongoing evaluation of the system and its ability to process auto-assignments as specified by the State.

5.9.4.13 Produce reports, as directed by the State, to assist in operating the IHCP Managed Care managed care program. Areas of OMPP interest include service utilization and trends and comparisons of delivery systems.

5.9.4.14 Provide written reports to the State quarterly presenting issues, trends, and recommendations regarding policies, procedures, and focus areas.

5.9.4.15 Accurately reimburse MCOs for appropriate capitation payments for recipient birth deliveries.

5.9.4.16 Maintain the current and historical capitation rate cells specific to each IHCP Managed Care Organization. This includes:

- Loading and verifying State approved capitation rates
- Maintaining historical capitation rates for current and previous MCOs
- Updating capitation rate cells as appropriate

5.9.4.17 Correctly, and in accordance to the schedule established by the OMPP, reimburse MCOs' capitation rates. Ensure payments are accurate.

5.9.4.18 Pay PCCM administrative fees to PCCM PMPs on a schedule specified by the State.

5.9.4.19 Generate, update, and adjust when necessary administrative fee payments and capitation payments.

Primary Medical Provider, Network, and Managed Care Organization Enrollment

5.9.4.20 Data-enter and enroll Primary Care Case Management (PCCM) and Risk-Based Case Management (RBMC) Primary Medical Providers (PMPs) into IHCP Managed Care according to established policies and procedures.

5.9.4.21 Enter complete PMP enrollment requests and PMP enrollment changes into Indiana*AIM* within five business days of receipt of enrollment form. This five-day period may be extended at the OMPP's discretion. This includes:

- Program changes from RBMC to PCCM or vice versa

- Voluntary and mandatory disenrollments

Follow acceptable procedures for processing and entering PMP enrollment and PMP enrollment changes.

5.9.4.22 Generate quarterly, and maintain a history of, PMP certification codes for use in claims processing referral management. Incorporate trending and peer group analysis.

5.9.4.23 Collect and maintain information on MCOs to facilitate provider and member communication and support financial and claims transactions. Collect and maintain information on MCO and providers, such as PMPs' scope of practice.

5.9.4.24 Enroll MCOs into IHCP Managed Care and generate confirmation letters to the MCO and the OMPP.

Recipient Enrollment Support

5.9.4.25 Generate PMP confirmation letters and mail to members.

5.9.4.26 Generate and make enrollment rosters and HIPAA 834 and 820 transactions available electronically to handle managed care enrollments as directed by the State to managed care organizations and others.

5.9.4.27 Process all eligible IHCP Managed Care members who have not chosen a PMP, and assign the member to an appropriate physician through Indiana*AIM*'s auto-assignment process. Eligible members who have not chosen a PMP must be auto-assigned by the timeframe established by the OMPP.

5.9.4.28 Maintain eligible members' enrollments in IHCP Managed Care by:

- Receiving information from the enrollment broker and maintaining it in Indiana*AIM*.
- Allowing the State or its designee access to, and update of, member enrollment information.
- Providing technical and operational assistance to resolve issues encountered by the State or its designee during the member enrollment update process.

5.9.4.29 Generate monthly electronic lists of Primary Medical Providers (PMPs) in various formats and on a schedule mandated by the State to the State and multiple contractors and organizations to be used in enrollment brokering and for other purposes.

5.9.4.30 Generate, upon request, lists of all specialists, facilities, and ancillary providers participating within the network (MCO Network Provider File). Distribute to other contractors as appropriate.

5.9.4.31 Provide a monthly listing to MCOs of known third-party liability resources for their enrolled members.

Claims Processing

5.9.4.32 Ensure that fee-for-service claims pay or deny correctly for individuals enrolled in managed care.

5.9.4.33 Adjudicate Encounter Transactions submitted by MCOs and make needed modifications to the Encounter Transactions adjudicate and adjustment process as directed by the OMPP.

5.9.4.34 Generate reports on MCO Encounter Transaction content compliance with preventative health and chronic diseases indicators as specified by the OMPP, and submit to the State by the end of the month following the submitting month.

Coordination Activities

5.9.4.35 Provide access to Encounter Transactions and other managed care data to designated state contractors.

5.9.4.36 Coordinate with other state contractors to assess and evaluate medical policy and prior authorization procedures in relation to managed care.

5.9.4.37 Coordinate managed care activities with the other state contractors to evaluate Encounter Transaction data.

5.9.4.38 Coordinate with MCOs, the Medical Policy Contractor's SUR unit, or other contractors as specified by the State to manage members with restricted cards who change delivery systems frequently.

5.9.4.39 Coordinate with the Medical Policy and Review Services Contractor to conduct DRG audits.

5.9.4.40 Contractor will provide knowledgeable staff to assist other managed care contractors with resolution of operational issues necessary for efficient program operation.

5.10 Waiver Program Support

5.10.1 Overview and Business Objective

The IHCP is a Federal-State medical assistance program which makes reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements. Currently, a number of IHCP Home- and Community-Based Services (HCBS) waiver programs are part of the IHCP Program operations are administered by the Division of Disability and Rehabilitative Services and the Division of Aging subject to an agreement with OMPP, which retains final authority for these programs. These waiver programs offer assistance to eligible members, allowing them to remain in non-institutional environments. Within each waiver program, there are specific services that can be accessed to meet individual needs. To be eligible, members must be at imminent risk of institutionalization in the absence of the waiver services. When an individual begins participating in the IHCP HCBS waiver program, he or she is no longer eligible to receive services under any other waiver.

The HCBS waivers currently offered through the IHCP are:

- Aged and Disabled
- Autism
- Developmental Disabilities (DD)
- Traumatic Brain Injury (TBI)
- Assisted Living
- Support Services
- Children with Serious Emotional Disturbance (schedule to end on 1/31/07)

For children under the age of 18, eligibility for waiver services is based on the income and resources of the child, not the child's parents.

The IHCP waiver programs are funded with both state and federal dollars. All waiver programs are administered with approval from CMS.

5.10.1.1 Business Objective

The State's objective for the IHCP HCBS waiver program is to provide services in a cost-effective manner to eligible members as an alternative to institutional living.

5.10.2 System Support

The waiver program uses automated features within Indiana*AIM* to:

- Generate State and Federal reports to support all HCBS waivers.
- Track and maintain waiver and expenditure information.
- Facilitate access to Indiana*AIM* by designated contractors for processing of waiver cases.

5.10.3 State Responsibilities

5.10.3.1 Provide policy and procedure assistance to the IHCP Waiver Unit and the Contractor to administer the HCBS waivers.

5.10.3.2 Provide the following recipient lists to the Contractor defining recipients for inclusion in the data extraction for the preparation of the CMS-372 (S) report:

- Persons with TBI in ICFs/MR and NFs
- Persons with autism in ICFs/MR
- Persons in such other waiver programs as may be added by the State.

5.10.3.3 Review, and enter online, the medical level of care for members participating in waiver programs.

5.10.3.4 Define, review, approve, and submit all CMS Federal waiver reports

5.10.4 Contractor Responsibilities

5.10.4.1 Provide review and analysis assistance as requested by the State to evaluate waiver issues.

5.10.4.2 Develop, implement, document, and maintain procedures for managing all activities related to the Waiver business function.

5.10.4.3 Review all waiver procedure codes and make necessary changes in the edit tables for TPL and Medicare before claims are incorrectly denied.

5.10.4.4 Research, analyze, and coordinate changes with the State and the IHCP Waiver Staff to ensure that all waiver reports are accurate prior to submission to CMS.

5.10.4.5 Conduct a quality review of all reports prior to submission to the State. Reports should be accurate and should balance with other reports when appropriate; for example, the State should be able to balance the data provided on the CMS-64 HCBS waiver reports with information on specified MAR reports. Similarly, provide documentation explaining significant (and unexpected) changes reported between the initial and lag CMS-372 (S) waiver reports for each waiver year.

5.10.4.6 Maintain detailed procedures documenting how the waiver reports are to be prepared and detailing the procedures used to verify the accuracy of the report information.

5.10.4.7 Prepare and update waiver provider manuals at least every six months as directed by the State.

5.10.4.8 Accept eligibility information for recipients enrolled in waiver programs from the State or State-mandated Contractor.

5.10.4.9 Conduct quality control activities to ensure waiver providers are enrolled accurately and in a timely manner.

5.10.4.10 Generate waiver reports in the time frame determined by the State.

5.10.4.11 Respond to questions and requests from the IHCP Waiver Unit regarding the waiver reports and any waiver issues, problems, or questions within ten business days of receipt. In cases where a problem or issue has been identified, the Contractor shall respond in writing. Responses shall include a definition of the problem, a plan for correcting it, and estimated time frames for completion of the correction.

5.10.4.12 Generate and submit to the State all final reports to CMS on a schedule determined by the State but no later than two weeks prior to the due date to CMS.

5.10.4.13 Provide and maintain trained and knowledgeable staff qualified to interface with the State and the Waiver Staff.

5.10.4.14 Provide sufficient waiver specialists for resolving provider issues.

5.10.4.15 Conduct waiver provider educational workshops as specified by the State.

5.10.4.16 Certify waiver providers according to OMPP/DDRS/DA criteria

Coordination Activities

5.10.4.17 Work with other units within the Contractor's organization, especially provider relations, claims payment, and claims adjustment units, to develop policies and procedures for resolving waiver-related issues. Intervention by the State should only be requested when shared efforts cannot resolve the problem in a timely manner. The State should always be contacted if the issue involves a potential policy modification.

5.10.4.18 Work with other state contractors to develop policies and procedures for resolving waiver-related issues. Intervention by

the State should only be requested when shared efforts cannot resolve the problem in a timely manner. The State should always be contacted if the issue involves a potential policy modification.

5.10.4.19 Coordinate with the Medical Policy Contractor's Prior Authorization Unit or other contractors as specified by the State to prevent duplication of services and changes in waiver eligibility status. The PA Unit should check to see if members are enrolled in a waiver program and, if so, contact and coordinate service authorization decisions with the waiver case management entity.

5.10.4.20 Coordinate with the State's compliance unit to train SUR workers on waiver-related issues or have the SUR unit contract with outside consultants to provide input on waiver-related issues.

5.11 Long-Term Care, Medical Level of Care Reviews and PASSR

5.11.1 Overview and Business Objective

The Long-Term Care (LTC) business function encompasses LTC claims processing. Indiana Case Mix audits which encompass the RUG-III version 5.12, 34 model, medical level-of-care (LOC) determinations for nursing facilities, and preadmission screening and resident reviews (PASRRs) for nursing facilities.

The LTC business function is a specialized component of other IHCP business functions (Provider Services, Provider Data Maintenance, Claims Processing and Reporting, and Member Data Maintenance). The purpose of the LTC function is to support the processing of nursing facility, large and small ICFs/MR (small ICFs/MR are commonly referred to as Community Residential Facilities for the Developmentally Disabled (CRFs/DD) or group homes), home health agency, HCBS waiver, and hospice claims through the maintenance of member -specific nursing facility data and provider-specific certification and rate data.

OMPP utilizes LOC and PASRR information, in conjunction with other State offices, to ensure that IHCP-pending eligibles receive the care, services, and placement that are appropriate to meet the individual's health care needs:

- Case Mix Audit/LOC/PASRR provides a review of residents in nursing facilities. The review process serves as a mechanism to ensure the health and welfare of the resident, as well as evaluating them against promulgated criteria to ensure that IHCP reimbursement is approved at the appropriate level of care. During Case Mix Audit, the

audit teams assess the need for nursing facility care and the provision of recommended specialized services for residents with Mental Illness/Mental Retardation or Developmental Disability (MI/MR/DD) or the need for a PASRR level II assessment.

- The Preadmission Screening (PAS) portion of the PASRR is performed by a separate contractor(s) for persons seeking admission to Medicaid-certified nursing facilities. Indiana uses its own PAS form, which is referred to as the Indiana Preadmission Screening or IPAS form. The IPAS form accomplishes all of the federal requirements of PAS. PAS is used to determine the need for nursing facility levels of care, including physical status, functional assessment (activities of daily living), alternate services, and/or placement. The determination process is performed by the State.
- The minimum data set (MDS) PASRR assessment findings will determine the necessity of a referral for a level II assessment to determine if the resident needs specialized services for MI/MR/DD or an alternate placement.

The Contractor's responsibilities are primarily to perform on-site reviews of IHCP patients, corresponding MDS forms, and medical charts and to reimburse according to the cost-based or case-mix rate established for each nursing facility. A separate Contractor is responsible for collecting the data, setting the rates, and storing the rates in a database.

5.11.1.1 Business Objective

The State's objectives for the LTC business function are to:

- Efficiently administer and manage the Indiana LTC program through LTC cost and utilization reports.
- Protect the health and welfare of institutionalized IHCP members, including all residents with mental illness or mental retardation.
- Ensure that providers are being reimbursed appropriately for each resident.
- Assure that members are served in least restrictive environment, and are provided choice of setting

5.11.2 System Support

The Indiana*AIM* system currently contains the following functionality to support the LTC business area:

- Accepts and processes LTC, which include Case Mix, Hospice, and HCBS waiver claims
- Loads facility-specific rates when electronically transmitted by OMPP's LTC rate-setting Contractor
- Provides on-line access to LOC information
- Accepts and maintains LOC information

- Generates reports on member -specific LTC facility data
- Generates reports on provider-specific certification and rate data
- Generates summary of findings and patient LOC determination letters

5.11.3 State Responsibilities

5.11.3.1 Data-enter medical level-of-care determinations into Indiana*AIM*.

5.11.3.2 Generate and distribute PAS-4B forms with determination.

5.11.3.3 Render medical LOC determinations for admissions into nursing facilities, large and small ICFs/MR, and waiver programs.

5.11.3.4 Prepare and provide large and small ICF/MR assessment information to the Contractor.

5.11.3.5 Provide nursing facility (NF), Hospice, and large and small ICFs/MR rates to the Contractor.

5.11.3.6 Approve schedule for monthly MDS-RUGs III-case mix, hospice, and waiver reviews/audits.

5.11.3.7 Approve changes to payment review/MDS-RUGs III-case mix/PASRR review forms, Summary of Findings Letter forms, and Patient LOC Determination Letter forms.

5.11.3.8 Establish appeal policies and procedures.

5.11.3.9 Develop LOC and MDS-RUGs III-case mix resident classification criteria for the Contractor to use in formulating LOC determinations when reviewing members in LTC facilities.

5.11.3.10 Coordinate electronic transfer of case-mix data from the rate-setting Contractor to the Indiana*AIM* Contractor.

5.11.3.11 Respond to general and case-specific LTC inquiries.

5.11.3.12 Contract for or maintain a tracking system of Indiana Pre-Admission Screening (IPAS)-only cases.

5.11.3.13 Rate-setting Contractor will provide to the Contractor MDS/RUG-III Case Mix rosters for each scheduled nursing facility audit.

5.11.3.14 Coordinate electronic transfer of HCBS waiver Plan of Care data from the systems used by the State's designated Contractor to the Indiana*AIM* Contractor

5.11.3.15 Coordinate the retrieval of HCBS waiver Plans of Care from the State's designated Contractor.

5.11.4 Contractor Responsibilities

5.11.4.1 Operate the LTC functions efficiently and effectively in full compliance with applicable state and federal policy, law, and regulation.

5.11.4.2 Provide and maintain staff knowledgeable in policy and procedures as they pertain to the LTC requirements of the IHCP program.

5.11.4.3 Provide a high level of customer service to the program stakeholders who interface with and rely on information, reports, and processes of the LTC system.

5.11.4.4 Provide quality assurance procedures to ensure that the LTC system produces information, data, and reports accurately, on time, and in a format that is easily understood.

5.11.4.5 Produce, maintain, and distribute documentation for reports that clearly defines each report and its function.

5.11.4.6 Data-enter medical level-of-care determinations into Indiana*AIM* for audits that have been performed for LOC payment, hospice, and PASRR.

5.11.4.7 Produce and maintain comprehensive, accurate written procedures documenting all major aspects of the LTC functions.

5.11.4.8 Produce all Indiana*AIM* LTC reports required by the State.

5.11.4.9 Identify facilities that are, or have characteristics of, Institutions for Mental Disease (IMDs), such as facilities with mentally ill populations of greater than 50 percent of the total population. Take necessary action to restrict IHCP payments to facilities determined to be IMDs.

5.11.4.10 Conduct Annual Payment Reviews or such reviews as required to validate LOC RUGs (Resource Utilization Groups) III resident classification and PASRR functions in all IHCP-certified nursing facilities, including LOC assessments for all IHCP LOC members, a sample of MI/MR residents, reviews of MDS data versus that recorded in charts, and resident observation and/or interview to validate the resident RUGs III classification, and a compilation report of Traumatic Brain Injury (TBI) residents found during Case Mix audits.

5.11.4.11 Conduct all payment assessments in accordance with the State criteria and MDS-case-mix expectations. Audits shall be conducted as frequently as deemed necessary, and each nursing facility shall be audited no less frequently than every 15 months.

5.11.4.12 Provide sufficient on-site facility review staff to perform the hospice, HCBS waiver, LOC payment/case mix payment, review, and PASRR functions. Minimum team staffing requirements include:

- A registered nurse
- A licensed social worker

5.11.4.13 Provide an LTC Manager, who is a registered nurse, in the Indianapolis office. The LTC Manager is a Key Staff position.

5.11.4.14 Meet with LTC provider or the designee twice during each Annual Payment Review process; upon arrival for an entrance conference and upon completion of the audit for an exit conference.

5.11.4.15 Advance notification to providers, for Case Mix Audits, of up to 72 hours shall be provided by the Contractor for all MDS audits, except for follow-up audits that are intended to ensure compliance with validation improvement plans. Advanced notification for follow-up audits shall not be given per 405 IAC 1-15-5(a).

5.11.4.16 Use standard State-approved preprinted LOC payment review/PASRR forms to evaluate the member and determine transfers in level of care.

5.11.4.17 Maintain at least a three month inventory of all standard preprinted State-approved forms used.

5.11.4.18 Use standard State-approved preprinted forms for case-mix reimbursement/MDS-RUGs III classification reviews as may be required by the State.

5.11.4.19 Provide and submit to the State the Quarterly Utilization Reports, as defined in 42 CFR 456.654 which sets forth specific evidence of activities, for CMS no later than 20 business days following the end of each calendar quarter.

5.11.4.20 Provide to the State a monthly report of PASRR/payment review/MDS-RUGs III classification reviews for each nursing facility.

5.11.4.21 Prepare and submit to the State a monthly report pertaining to on-site reviews; report to include date of review, provider name and number, and city.

5.11.4.22 Update, maintain, and submit new/revised forms and manuals to the State within 30 business days after receiving the State approval, and maintain updated manuals and forms for the LOC payment review/PASRR/MDS-RUGs III-case mix

functions. The updated manuals and forms will be utilized within 30 business days of receiving State approval for usage.

5.11.4.23 Electronically submit to the State and ISDH a monthly listing of all case mix audits completed during a given month.

5.11.4.24 Conduct reconsiderations and compile and present evidence on behalf of the State at any LOC hearing or any subsequent litigation that may arise from appeals.

5.11.4.25 Provide a Reconsiderations Nurse, a registered nurse in a separate position, to conduct reconsiderations, represent the State at appeal hearings, and review determinations of team audits.

5.11.4.26 Prepare, and forward to the State within 20 business days of the end of the month, a summary report of LTC facilities reviewed during the month, including a report on RUGs III findings.

5.11.4.27 Provide Business Objects queries and other data gathering to assist the state in program/policy determinations.

Coordination Activities

5.11.4.28 Refer instances of suspected fraud, abuse, neglect, or exploitation to State and federal agencies designated by the State and as required by law, policy or rule.

5.11.4.29 Coordinate activities with the Medical Policy and Review Services Contractor to ensure proper reimbursement for nursing facilities.

5.11.4.30 Coordinate with the Medical Policy and Review Services Contractor to set policy to coordinate claims payment in relation to LTC claims.

5.11.4.31 Coordinate with Bureau of Quality Improvement Services (BQIS), DDRS, and DA regarding on-site reviews, incident referrals and reports.

5.11.4.32 Coordinate with the Division of Disability, and Rehabilitative Services (DDRS) and the Division of Aging for the insert and update of waiver plans of care on Indiana*AIM*.

5.12 Management and Administrative Reporting

5.12.1 Overview and Business Objective

The Indiana Management and Administrative Reporting (MAR) function provides information retrieval and reporting to support policy planning, program evaluation and decision-making, fiscal planning and control, federal reporting, and operational planning and control. Information is retrieved from various Indiana*AIM* tables for analysis, summarization, and reporting.

Indiana*AIM* extracts data monthly and summarizes detailed data from Claims, Reference, Member, and Provider functions for use by the MAR component of AIM. The summarized data provides the input for the MAR windows and reports. MAR windows are used by OMPP staff to access information based on variables entered by the user. When screen-related information is requested, the summarized data is accessed, based on the selected variables entered on the window, and returned to populate the window. MAR reports are generated on a monthly, quarterly, and annual basis to meet CMS reporting requirements. MAR provides OMPP with a variety of information to support the day-to-day management of the IHCP. Examples of MAR information reporting include:

- Administrative and financial reporting such as:
  - Program expenditure information
  - Fiscal planning and control
  - Statistical and Federal reporting
  - Policy planning and evaluation information
- Operational statistics such as:
  - Claims processing activity
  - Billing and processing time
  - Claim denial information
  - Analysis of provider enrollment, participation, billing lags, processing time statistics, and claim-related error characteristics
  - Analysis of recipient enrollment and participation by federal and state eligibility classifications and geographic location

5.12.1.1 Business Objective

The objectives of the MAR reporting function include:

- Meet all federal and state reporting requirements through the provision of accurate and timely reports.
- Provide OMPP with accurate and timely financial and statistical reports to assist with fiscal planning, control, monitoring, program and policy development, and evaluation of the IHCP. The Contractor shall verify accuracy of the reports against other systems.

5.12.2 System Support

The Contractor shall operate the enhanced MAR application. This application includes the following features to support MAR:

- Extracts data on a monthly basis from the member, provider, reference, and claims history files, and provides the ability to export data
- Summarizes and loads the data for input for the MAR windows and reports, and maintains 36 months of history
- Provides highly flexible, online, Windows-based, pull-down, menu-driven, 4GL screen capabilities for data access using predefined reporting parameters and reporting templates
- Generates monthly, quarterly, and annual state and federal reports
- Produces Medicaid Statistical Information System (MSIS) tapes for CMS
- Provides counts, based on meaningful units, by service category, and defined by the State, of services, claims, and unduplicated members and providers
- Tracks and reports on expenditures funded by IHCP and State-only programs for special populations
- Provides expenditure, eligibility, and utilization data to support budget forecasts and tracking and IHCP modeling

5.12.3 State Responsibilities

5.12.3.1 Provide and report to the Contractor any additional information, not provided by the Indiana*AIM* system, necessary to understand and correctly complete the CMS-64 Quarterly Statement of Expenditures.

5.12.3.2 Provide and report to the Contractor any data required for complete financial reporting that is not generated by the system operated by the Contractor.

5.12.3.3 Review and approve the Contractor-prepared CMS-64 report.

5.12.3.4 Assist in determining and approving changes or additions to state and federal categories of service, eligibility categories, provider type and specialty codes, district codes, accounting codes, and other codes necessary for producing the reports.

5.12.3.5 Respond to all requests from other parties for data on the IHCP that require the use of MAR reports.

5.12.3.6 Review balancing reports to ensure internal and external report integrity.

5.12.4 Contractor Responsibilities

5.12.4.1 Operate the MAR system efficiently and effectively in full compliance with applicable state and federal policy, law, and regulation.

5.12.4.2 Provide and maintain staff knowledgeable in policy and procedures as they pertain to the MAR requirements of the IHCP program. Provide at least one Designated MAR Analyst to work at the direction of the State, separate from other reporting positions, qualified by education and experience to analyze MAR reports.

5.12.4.3 Provide ongoing MAR training to the State or other Contractor staff as determined necessary by the State and in accordance with the Contractor's training analysis.

5.12.4.4 Provide a high level of customer service to the program stakeholders who interface with and rely on information and reports generated by the MAR system.

5.12.4.5 Provide quality assurance procedures to ensure that the MAR system produces information, data, and reports accurately, on time, and in a format that is easily understood.

5.12.4.6 Produce and maintain comprehensive, accurate written procedures documenting all major aspects of the MAR system, including clear definitions of all field calculations and data used in the calculations.

5.12.4.7 Maintain the MAR function of Indiana*AIM* according to all state and federal requirements.

5.12.4.8 Process MAR file updates at least monthly at the end of the monthly financial reporting period. This shall be a complete update process, including both fee-for-service and Encounter Transactions.

5.12.4.9 Produce the MSIS tapes for CMS in accordance with required CMS time frames. Respond to CMS questions about the submitted MSIS tapes and make corrections as needed to respond to CMS questions.

5.12.4.10 Deliver to the State a hard copy and electronic copy of monthly ~~2082~~ CMS MSIS reports in a format and on a schedule directed by the State.

5.12.4.11 Generate all reports to be sent to CMS in the media required.

5.12.4.12 Prepare the CMS-64 report with all systems-produced data for delivery to the State, and incorporate additional information provided by the State under MAS-1 and MAS-2. Validate all numbers on the report before delivery to the State. The CMS-64 report shall be submitted to the State within 10 business days of the end of the quarter.

5.12.4.13 Ensure that deposits made by the Contractor during the reporting quarter balance to the information contained on the CMS-64.

5.12.4.14 Clearly define and recommend to the State changes or additions to state and federal categories of service, eligibility categories, provider type and specialty codes, district codes, accounting codes, and other codes necessary for producing MAR reports.

5.12.4.15 Respond to State requests for information about MAR reports no later than three business days after the request. At a minimum, the Contractor shall provide an initial response within three business days.

5.12.4.16 In cases where a problem has been identified on a MAR report, prepare and submit to the State a corrective action plan or detailed information explaining the nature of the problem, how the problem will be resolved, when the problem will be fixed, and who is responsible for resolving the problem. This information shall be delivered to the State within 10 business days.

5.12.4.17 Save final output files for at least six months.

5.12.4.18 Perform necessary corrections and reruns, and verify and distribute MAR reports within the time frame specified by the State.

5.12.4.19 Report Encounter Transactions data, and compare the information to similar data elements for fee-for-service claims.

5.12.4.20 Respond to State requests for information concerning the reports within the time frame as requested by the State.

5.12.4.21 Produce, verify, and submit to the State and CMS (including, but not limited to, the CMS-64 and CMS-37 reports) all MAR reports and other outputs within required time frames and

according to the state and federal specifications. Balance MAR reports against reports generated from other components of the system (for example, selected claims and financial reports).

5.12.4.22 Balance MAR screen and report data to comparable data from other MAR screens and reports to ensure internal validity and to non-MAR screens and reports to ensure external validity. Provide an audit trail of the balancing process. Deliver the balancing report to the State with each MAR production run.

5.12.4.23 Report to the State any imbalances existing in the MAR screens and reports, including the reason for the imbalance, within three (3) business days of the discovery of the imbalance.

5.12.4.24 Maintain 36 months of claims history and supporting data.

5.12.4.25 Assign a separate single point of contact that is responsible for data validation and performing trending analysis on the MAR data to detect anomalies.

5.12.4.26 Produce the Quarterly Dental Report as defined and directed by the State.

Coordination Activities

5.12.4.27 Coordinate CMS-64 preparation activities with other State Contractors to ensure that the CMS-64 report is delivered to the State on time.

5.13 Data/Information Reporting

5.13.1 Overview and Business Objective

OMPP uses several decision support tools to access IHCP information, support the management of the IHCP program, and make decisions regarding the future of the program. These include:

- data/information reporting system within Indiana*AIM,*
- Milliman Data Analysis System and
- COGNOS tools which support the Indiana FSSA data warehouse.

The Data/Information Reporting tool within Indiana*AIM* provides on-line report and data extraction capabilities that allow the user to access and manipulate information from claims history, prior authorization, reference, member, and provider tables to meet that user's needs. Information obtained through this data/information reporting function is used for budget forecasting, program analysis, and program management. Information is accessed via a user interface, developed using

BusinessObjects. This tool allows users to create and execute database queries and present the results in a number of ways. Results can be presented as a formatted hard-copy report or electronic file or can be imported into Windows applications. The user interface allows users to create tables to store results or to use in other queries. The Contractor's Reporting Specialist assists in the formulation and execution of BusinessObjects-generated queries.

The State has contracted with Milliman to provide a Data Analysis System. The Data Analysis System consists of an Executive Information System (EIS)--MedInsight--and a Decision Support System (DSS), MedInsight, a data/information query tool. The Data Analysis System is used to perform complex analyses of data to support budget forecasting, fee and rate analysis, utilization analysis, trends-over-time analysis, medical policy development and refinement, and assessment of access to care and quality of care in fee-for-service and managed care settings.

The Data/Information Reporting function within Indiana*AIM* provides a mechanism for State and Contractor staff to perform queries against data that is summarized and stored in Data Universes within BusinessObjects.

5.13.1.1 Business Objective

Objectives for the Data/Information Reporting function include:

- Provide a mechanism for the State and Contractor to perform analytical queries against current and historic data.
- Provide a mechanism that allows the State to respond to legislative or executive-level questions promptly.

5.13.2 System Support

Indiana*AIM* includes the following features to support data/information reporting:

- Provides the BusinessObjects tool, which allows the user direct access to the information on the Decision Support System (DSS) database
- Provides a graphical user interface, which allows the user to specify data element-specific report selection criteria, sort, and report format and display characteristics
- Provides an online library/catalog of standardized or frequently used data/information queries and selection criteria for routine reports that can be requested and run by authorized State personnel
- Updates provider, member, reference, managed care, prior authorization, financial and claims tables weekly
- Links claims history information into the database
- Creates data transfers monthly for the Data Analysis System
- Generates an actuarial extract monthly for the Actuarial Contractor

- Generates data extracts for the Hospital Rate-Setting Contractor

5.13.3 State Responsibilities

5.13.3.1 Define specifications for data/information queries.

5.13.3.2 Create and execute data/information queries.

5.13.3.3 Prioritize requests for reports and file extracts.

5.13.3.4 Designate a State representative to serve as a point of contact for the contractors. The State representative will be responsible for reviewing the data/information requests, determining what reporting tool should be used to execute the query, and prioritizing the queries.

5.13.3.5 Designate a State representative to manage information requests from other agencies and contractors and to approve changes or additions of data elements and tables within the system.

5.13.3.6 Develop guidelines so that the State and Contractor can determine which tool is appropriate to use to execute queries.

5.13.4 Contractor Responsibilities

5.13.4.1 Maintain the BusinessObjects software and database architecture to support State- and Contractor-initiated Business Objects queries.

5.13.4.2 Ensure 99.999 percent availability of the database for reporting and querying on Monday through Saturday during the hours of 6 am and 11:59 pm.

5.13.4.3 Meet with the State and other contractors on a regular basis to review and prioritize data/information report and data extract requests.

5.13.4.4 Document and advised the State and the requester when the agreed-upon time frame for a query is not going to be met.

5.13.4.5 Maintain and submit a report or spreadsheet identifying the status of each data/information request. At a minimum, the report will include the status and priority of the requester, who requested the query, and the agreed-to completion date.

5.13.4.6 Provide user-defined file extracts on electronic media to be used by the State for IHCP actuarial analysis. All file extracts shall be reviewed and verified prior to delivery.

5.13.4.7 Update the data/information reporting software with new tables and fields as needed.

5.13.4.8 Maintain 120 months (ten years) of claims history and supporting data for use by the data/information reporting software. The current environment supports seven years. The Contractor shall meet the ten year requirement within 180 calendar days of the contract start date.

5.13.4.9 Generate data for transfer to the Data Analysis Contractor in the media and within the time frame specified by the State.

5.13.4.10 Provide one on-site Data and Report Analyst, a full-time position to work at the direction of the State to assist with the design, prioritization, and execution of data/information reports. This person shall be qualified by education and experience, including a college degree and at least two (2) years in health care data analysis. This is a Key Staff position.

5.13.4.11 Create and execute data/information queries as directed by the State.

5.13.4.12 Work closely with the individual(s) requesting the query to confirm the Contractor's understanding of what has been requested.

5.13.4.13 Validate query results and extracts before delivering them to the State or other contractors.

5.13.4.14 Deliver data/information reports, query results, and extracts to the requester. The Contractor shall include detailed documentation of the assumptions and parameters used to produce the output in user-friendly terms (such as use of paid amount and allowed amount).

5.13.4.15 Provide ongoing training to users as requested by the State. Include regular and comprehensive training in BusinessObjects and such other tools as may increase the efficiency of State staff using the DSS, at the direction of the State.

5.13.4.16 Provide assistance to State and other contractors in developing and executing queries.

5.13.4.17 Maintain a log of query requests and ones that have been run. Analyze long-running queries and make recommendations and changes to improve the efficiency of repeated queries.

5.13.4.18 Review query requests with the requester to ensure that the correct tables are accessed to retrieve data that meets the requester's requirements.

5.13.4.19 Provide a State-approved manual that instructs users on how to create queries; provides the table structures, including the data elements; and provides examples.

5.13.4.20 Make recommendations about queries that should become coded production reports.

5.13.4.21 Respond to requests for new reports or changes to data elements within the time frame specified by the State.

5.13.4.22 Deliver requested data/information reports within the time frame specified by the State.

5.13.4.23 Update the DSS database member, provider, reference, managed care, prior authorization, financial and claims history tables on a weekly basis within two business days following the completion of a financial cycle.

5.13.4.24 Respond to requests for technical assistance on using the Data/Information Reporting software within one business day of receipt of request from the State and within two hours in urgent situations as defined by the State.

5.13.4.25 Generate and transmit data to the Data Analysis Contractor on a monthly basis within the time frame specified by the State.

5.13.4.26 Generate data for transfer to the Actuarial Contractor within the time frame specified by the State.

5.13.4.27 Generate data for transfer to the Rate-Setting Contractor within the time frame specified by the State. Generate data for transfer to other contractors as directed by the State and within the time frame specified by the State.

5.13.4.28 Generate data for transfer to other contractors as directed by the State and within the timeframe specified by the State.

5.13.4.29 Correct all data extract problems within five business days of problem identification. The Contractor shall notify the State within 24 hours of problem identification that a problem has been identified. The Contractor shall also notify the State when the problem has been corrected.

5.13.4.30 Reduce interruptions and downtime due to system maintenance to a minimum to ensure that queries can be run.

5.13.4.31 Maintain full documentation and data to enable the state to explain and reconstruct any Federal report, moving toward a seven year period of retention.

5.13.4.32 Provide access to the database and reporting software including licensure to entities as the State deems necessary.

Coordination Activities

5.13.4.33 Develop coordination methods for extract transfers to other contractors.

5.13.4.34 Develop methods to resolve data discrepancies with other contractors.

5.13.4.35 Work with other contractors to develop extracts.

5.13.4.36 Review query and extract requests received from other contractors, and meet with the requesting Contractor to confirm and validate the query request.

5.13.4.37 Work with other contractors to verify requested queries.

5.13.4.38 Maintain and publish a metadata repository which clearly defines all data elements including valid values and documents the entity relationships.

5.13.4.39 Work with DTS Architecture and Standards to support development of an integrated FSSA meta data repository and to resolve redundancies and inconsistencies.

5.14 Systems Operations, Integrated Testing Facility, and Disaster Recovery

5.14.1 Overview and Business Objective

To ensure that the IHCP operates according to federal and state regulations, it is imperative that the Contractor maintains a system operational environment that ensures:

- Accurate, complete, and timely system processing
- Availability to systems applications and telecommunications during hours specified by the State
- Fully-tested system changes prior to implementation in the production environment
- Establishment and adherence to back-up and recovery procedures
- Readiness to reestablish a production environment in the event of a disaster

This section presents operations responsibilities for system operations, maintaining an integrated test environment, and disaster recovery.

5.14.2 System Operations

System operations encompass the activities performed by the Contractor to execute IHCP processing and reporting cycles; maintain internal controls; and perform routine backup of programs, tables, and files. The Contractor shall provide sufficient numbers of personnel, at the appropriate skill levels, to successfully operate and monitor Indiana*AIM*.

These personnel shall be distinct from the maintenance and modification personnel described in Section 5.15.

5.14.1.1 Integrated Test Facility

The integrated test facility (ITF) is an environment to implement system changes during operations while ensuring quality control is maintained. The environment includes a test version of online batch programs and system tables, which are identical to the production environment.

The Contractor and State both use ITF. The Contractor will thoroughly test all changes before moving any changes into production. The Contractor must perform quality control checks in the ITF to ensure that changes produce the expected results without any unanticipated impact in the production environment.

The ITF allows the State to monitor the accuracy of Indiana*AIM* and test changes to the system before promotion to production by processing test data and other transactions through the system without affecting normal operations

5.14.1.2 Disaster Recovery

Indiana*AIM* shall be protected against hardware, software, and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery. Full and complete back-up copies of data and software shall be maintained and proficiently backed up on tape or optical disk and stored in an approved off-site location. The Contractor will maintain or otherwise arrange for an alternate site for its system operations in the event of a catastrophe or other serious disaster. For purposes of this RFP, disaster means an occurrence of any kind whatsoever that adversely affects, in whole or in part, the error-free and continuous operation of the system or affects the performance, functionality, efficiency, accessibility, reliability, or security of the system. The Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and Contractor will jointly determine when unscheduled system downtime will be elevated to a disaster status. Disasters may include natural disasters, human error, computer virus, or malfunctioning hardware or electrical supply.

5.14.1.3 Business Objective

The objective is to provide systems that effectively and consistently meet processing requirements to support the operational business activities of the IHCP

5.14.3 System Support

This business function uses the following automated features within Indiana*AIM*:

- Generation of reports to support system operations
- Transmission of files and data through automated processes
- Maintenance of an ITF

5.14.4 State Responsibilities

System Operations

5.14.4.1 Monitor the Contractor's daily operation of Indiana*AIM* and supporting functions.

5.14.4.2 Monitor the Contractor's file maintenance process to ensure integrity of the database tables and files.

Integrated Test Facility

5.14.4.3 Use ITF to monitor test and operations activities by submitting test inputs, modifying test tables, and reviewing system outputs.

5.14.4.4 Review and approve test results prior to the Contractor promoting changes to production.

5.14.4.5 Attend Contractor walkthroughs to validate test cases and test case results for accuracy and quality.

Disaster Recovery Plan

5.14.4.6 Approve disaster planning documentation and procedures.

5.14.4.7 Approve proposed off-site procedures, locations, and protocols.

5.14.4.8 Attend the Contractor's disaster recovery demonstration and review the results.

5.14.4.9 Monitor progress of reestablishment of normal business functions in the event of a disaster.

5.14.5 Contractor Responsibilities

System Operations

5.14.5.1 Maintain and operate Indiana*AIM* according to State-approved requirements.

5.14.5.2 Establish and adhere to processing schedule requirements as specified by the State.

5.14.5.3 Provide system and application availability according to specifications established by the State.

5.14.5.4 Provide availability of online access to Indiana*AIM* to other State departments and contractors as specified by the State.

5.14.5.5 Make changes to the recipient database tables when requested by the State. The updates shall be completed within 24 hours of request.

5.14.5.6 Monitor and balance all cycles (for example, daily, weekly, monthly, etc.) and jobs to ensure they are completely executed. Notify the State when cycle problems are identified.

5.14.5.7 Resolve ABENDS during execution of the cycles.

5.14.5.8 Perform internal control reviews on Indiana*AIM* operations, notify the State of any deficiencies found, and correct the deficiencies identified through the reviews.

5.14.5.9 Support immediate restoration and recovery of lost or corrupted data or software.

5.14.5.10 Establish and maintain in electronic format a weekly back-up that is adequate and secure for all computer software and operating programs; database tables; files; and system, operations, and user documentation.

5.14.5.11 Establish and maintain in an electronic format a daily back-up that is adequate and secure for all computer software and operating programs databases tables; files; and systems, operations, and user documentation.

5.14.5.12 Print and distribute Indiana*AIM* cycle reports.

5.14.5.13 Create extract tapes for distribution to the State or State contractors.

5.14.5.14 Maintain system operations manuals and procedures and cycle logs.

5.14.5.15 Maintain archives of the system and Indiana*AIM* in accordance with the requirements of this RFP.

5.14.5.16 Provide sufficient system operations staff with the appropriate skills to perform the requirements presented in this RFP.

Integrated Test Facility

5.14.5.17 Operate and maintain complete, separate, and current on-line development, system testing, regression testing, and acceptance testing environments, including batch, on-line programs, and test database tables and files.

5.14.5.18 The Contractor shall utilize automated testing tools to perform regression testing prior to promoting to production. The regression environment must be capable of restoring to a baseline. The Contractor shall review regression test cases that do not perform as expected to determine if the test case is no longer valid or if a system issue exists as a result of system changes. If the case is no longer valid, the Contractor shall adjust the case. If a system issue exists, the Contractor shall repair the system issue, restore to the baseline, and re-run the regression test cases. The regression testing environment must be in place by 1/1/09

5.14.5.19 The Contractor shall establish a testing team comprised of testing analysts to perform targeted system test cases and review the regression testing results. The Contractor must obtain approval for all testing analysts prior to assigning the testing analyst to perform services governed by this contract.

5.14.5.20 The Contractor shall track all system test cases created for specific system enhancements and whether the test cases meet the expected results.

5.14.5.21 The Contractor shall track the percentage of system test cases for each month that meet the expected results without a defect.

5.14.5.22 Recognizing that failed test cases indicate billable system rework and add expense to the State, the Contractor shall multiply the monthly modification billing by the percentage of test cases that met the expected results without a defect to determine the monthly modification dollars charged to the State.

5.14.5.23 Identify providers, members, and claims used for testing to maintain the integrity of routine claims processing operations and files.

5.14.5.24 Generate test output, including tables, files, reports, tapes, and micromedia. Output shall be separately identified and clearly labeled. Test outputs shall be separate from routine

Indiana*AIM* outputs and available to the State during business hours without notice.

5.14.5.25 Perform claims processing in a simulated production environment.

5.14.5.26 Provide the State with online access to ITF and test database tables and files to submit test data independently without notice to the Contractor.

5.14.5.27 Accept test claims data submitted by the State, without notice to the Contractor, on hard-copy or electronic media.

5.14.5.28 Report on the results of test cycles, including the expected impact of edit, audit, and pricing changes and compare those results to the actual processing results.

5.14.5.29 Initiate and conduct walk-throughs of system test changes that are ready to be moved into the production environment. Walkthroughs of test cases and results shall include a discussion of programs that are impacted by the system change. The Contractor shall include an online demonstration verifying the accuracy of system changes and handouts of test results. Walkthrough materials will be available for State review after the walkthrough. Walkthroughs will be conducted for system changes involving major modifications or where a significant number of programs and/or tables are modified or at the State's discretion.

5.14.5.30 Develop and execute State-approved test cases for system changes.

5.14.5.31 Maintain ITF functions, database tables and files, and data elements necessary to meet State requirements and simulate production.

5.14.5.32 Produce, review, and submit, by noon the next business day, control reports generated for each test update and processing cycle run.

5.14.5.33 Provide a written report before production promotions, in a State-approved format, on the results of integrated test cycles within seven business days of running the cycles and include a comparison of the expected impact of edit, audit, and pricing changes against actual processing results.

Disaster Recovery Plan

5.14.5.34 Demonstrate an ability to meet back-up requirements by submitting and maintaining a Disaster Recovery Plan that addresses:

- Checkpoint and restart capabilities
- Retention and storage of back-up files and software
- Hardware back-up for the servers
- Hardware back-up for data entry equipment
- Network back-up for telecommunications

5.14.5.35 Provide back-up processing capability at a remote site from the Contractor's primary site such that normal payment processing and other system and services, deemed necessary by the State, can continue in the event of a disaster or major hardware problem at the primary site.

5.14.5.36 Demonstrate a disaster recovery capability no less than every two calendar years in accordance with 45 CFR 95.621 (f).

5.14.5.37 In the event of a catastrophic or natural disaster, resume normal business functions at the earliest possible time, not to exceed 30 calendar days.

5.14.5.38 In the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment or electrical supply, resume normal business functioning at the earliest possible time, not to exceed 10 calendar days.

Coordination Activities

5.14.5.39 Develop coordination methods for required system operational activities with other contractors, including back-ups of information sent or accepted.

5.14.5.40 Provide access to the ITF for other contractors when changes are being tested that involve them.

5.14.5.41 Plan and coordinate disaster recovery activities with other contractors and the State.

5.14.5.42 Maintain a staff to assist the State in User Acceptance Testing. This staff must consist of qualified business users, not systems engineers.

5.14.5.43 Include multiple environments for testing, including a regression testing environment, a systems testing environment and a user acceptance testing environment.

5.15 System Maintenance and Modification

5.15.1 Overview and Business Objective

Changes to the software and other component parts of Indiana*AIM* are made and tracked through the Maintenance and Modification function. This section describes how requested changes to the system will be categorized, how the Contractor must provide staffing to support this objective, activities that must be performed, and how State and Contractor responsibilities are distributed.

5.15.1.1 Business Objective

The objectives of the System Maintenance and Modification business function are as follows:

- Expediently identify, document, and track maintenance system changes.
- Identify, design, and implement system modifications, which improve the effectiveness of the Medicaid business processes, especially in the area of cost-savings, and enhance the value of Indiana*AIM*.
- Continuously identify process improvements to increase efficiency and reduce time required to develop and implement system changes, with ongoing focus on maintaining quality and decreasing "re-work"
- Continuously improve system change estimating processes.
- Maintain hours worked against priority projects at a State-specified level.
- Accurately implement system maintenance and modification Change Requests within timeframe allocated.
- Expediently identify, document, and track maintenance system changes.
- Serve as liaison to improve communication and coordination between the Contractor, the State, and all other contractors to effectively facilitate system changes in systems that support Medicaid business functions.
- Ensure that project management activities include communication and coordination between staff responsible for implementing system modifications,

including the Contractor, other contractors, and State business and system staff.

5.15.1.2 Classification of System Changes

Changes to the system will be categorized as either maintenance or modification.

System maintenance includes but is not limited to the following types of maintenance support categories:

Maint-1	Activities necessary to correct deficiencies (i.e., incorrect pricing logic, incorrect logic for edits and audits, incorrect report calculations, etc.) within Indiana*AIM*, including deficiencies found after implementation of modifications incorporated into Indiana*AIM*
Maint-2	Activities necessary for the system to meet the performance requirements detailed in this SOW, including operations support
Maint-3	Activities necessary to ensure that data, tables, programs, and documentation are current and that errors are found and corrected
Maint-4	Data maintenance activities for updates to tables, including database support activities
Maint-5	Changes to scripts or system parameters concerning the frequency, number, sorting, and media of reports
Maint-6	Changes to disposition parameters (reference file) for established edit or audit criteria

Modifications result when the State, based on input from other contractors or the Contractor, determines that an additional requirement needs to be met that results in a change to existing table structures or current processing logic.

5.15.1.3 Maintenance and Modification Staffing and Task Activities

Maintenance and modification activities will be accomplished within the parameters detailed below, with no additional cost for machine-time or documentation development.

Staffing Requirements

The Contractor must provide a Systems Director to oversee the technical staff assigned to the maintenance and modification teams. This position will also serve as the primary technical liaison between the Contractor and the State for all technical and/or systems related activities.

The Contractor shall also provide a minimum of two (2) Database Administrators (DBAs) to manage and maintain all Indiana*AIM* databases and associated data.

To support reference file maintenance, the Contractor must retain, at a minimum, 2 (FTE) Business Analysts.

The Contractor shall provide a Systems Architect 1 (FTE). The Systems Architect will work with State information technology organizations at the direction of the State to develop an overall strategy for evolving Indiana*AIM* to meet the changing needs of the IHCP and to capitalize on the opportunities presented by advances in technology. The Systems Architect will utilize this strategy to facilitate system modifications and systems integration efforts. The Systems Architect will also be responsible for assisting the State in integrating IHCP data into a cohesive data architecture and data management strategy. This data architecture will be a product of the enterprise-wide vision and governance established by the State. The architecture and the data management strategy will be an evolving set of directives to include tools, techniques, deliverables, naming standards, processes, and data sharing strategies. The Systems Architect shall have a thorough understanding of:

- Medicaid and managed health care business processes and best practices,
- The structure of medical claims payment systems including the database and supporting technologies, and
- Existing and emerging technologies which may be applied to enhance Indiana*AIM* or improve IHCP business processes

At a minimum, the Contractor must provide two (2) UNIX System Administrators, two (2) LAN/WAN administrators and adequate staffing to maintain a data center 24 hours per day, seven days per week.

The State will approve all systems positions prior to assignment to any work covered under this contract.

Maintenance staffing levels are determined by the Contractor, subject to the approval of the State. The Contractor shall provide a staffing level sufficient to process all maintenance support activities identified in Section 5.15.1.2. Maintenance staff must be specifically identified. Maintenance staff shall

not perform services billable as modifications without approval from the State.

The Contractor shall secure appropriate staffing levels to ensure that production support activities are timely and function appropriately, maintaining compliance with all system and operational ongoing performance requirements including system availability.

Modification Pool

The Contractor will provide a pool of resources (the Modification Pool) to design, develop and implement system modifications. This resource pool will be comprised of Project Managers (Cost Proposal category 1c), System Engineers (Cost Proposal Category 1f), Programmers (Cost Proposal Category 1g), Business Analysts (Cost Proposal Category 1g), Testing Staff (Cost Proposal Category 1g), Documentation Specialists (Cost Proposal Category 1k), and such other categorized staff as may be approved by the State. The Contractor shall submit a plan for staffing this Modification Pool at least annually or as directed by the State. This staffing plan is subject to approval by the State.

The Contractor will be reimbursed at the lesser of the hourly rate identified in the Contractor's Cost Proposal or the following:

- For positions in category 1c, $100 per hour.
- For positions in category 1f, $80 per hour.
- For positions in category 1g, $65 per hour.
- For positions in category 1k, $55 per hour.
- For positions in any other category, an amount approved in advance by the State.

The State will approve in advance the staff appointed to modification pool positions. The State reserves the right to approve or reject and require replacement of any system modification staff.

The Contractor will account for the time of all modification staff, including detail of the Change Requests, activity types, and the detailed activities worked by each staff person. The Contractor will invoice the State for modification work reported after each month. The State will pay invoices for all work done in conformance with the approved staffing plan and

these billing requirements, over and above the Contractor's bid price, up to a maximum of $4,000,000 per year.

The intent of both the State and the Contractor is to fill these positions with a well-balanced team which as a whole is effective and efficient in making required changes to Indiana*AIM*. The State reserves the right to reduce the staffing plan and replace categories of staff or certain individuals with State staff or other contracted staff. For example, the State may elect to outsource all testing, and replace testing staff with other contracted testing staff; or the State may elect to replace Project Managers with State project managers. In such cases, the Contractor will continue to provide office space and equipment for the job function, but may not bill for the hours worked or the infrastructure cost to support the job function.

The Contractor and State will review the required staffing levels by position and skills set at the end of each contract year or on a schedule specified by the State. The State will consider the recommendation of the Contractor, but will make all decisions regarding the composition and assignments of this staff.

Location of Systems Staff
All technical staff supporting the Indiana Medicaid operation must be based at the Contractor's Indianapolis-based Medicaid operational location. Any supplemental technical staff that may be assigned to support the Indiana Medicaid Program must be currently employed by the Contractor and physically located within the continental United States. All technical staff located outside of the Contractor's Indianapolis-based Medicaid location, requires prior written approval from the State.

5.15.1.4 Change Request Review/Approval and Prioritization

Initial Review Process (IR)

New change requests, system modifications and maintenance, will be submitted according to the State's change control process. The State shall approve and prioritize all change requests.

The State shall classify each change request as modification or maintenance based on the definitions provided in this contract. The State shall designate the severity of any deficiency, maintenance Change Requests.

The Contractor shall immediately inform the State of identified deficiencies and shall submit a Change Request for any identified deficiencies within 3 days or in a timeframe specified by the State.

5.15.1.5 Maintenance and Modification Project Tracking and Reporting

Change Request Tracking System
The Contractor will maintain an automated system for tracking Change Requests through the development cycles and log system hours against Change Requests, activity types, and specific activities. The Contractor will provide weekly reports in the format and media specified by the State.

The Change Request tracking system and inventory listing will include, at a minimum, each outstanding change request (for both active and completed changes), Change Request name and number, status, status date, business area, expected completion date; progress toward completion, including total hours worked; the estimated staff hours to complete; and additional attributes upon request. The hours listing, at a minimum, will include the Change Request, billing staff person, hours, project phase, and date the work is performed.

The State reserves the right to require the Contractor to use a State specified Change Request Automated Tracking System.

Project Documentation
The Contractor must provide, accessible by State and Contractor staff, a web-based project management application that provides a single repository of critical project management information and system documentation, including the minimum requirements outlined below:

- Ability to view documented business processes and contract requirements for all operational units, functions and Contractor responsibilities
- Ability to view the Indiana*AIM* data model in a user friendly manner
- Access to all Indiana*AIM* business and technical design documentation
- Change Request Library to monitor/track a Change Request from the business requirement/process through the development process including all testing results. Ability to project manage/track the progress of a Change Request (i.e. requirement gathering

meeting/collaboration, high and detail level requirements, walkthrough documentation)
- Expanded parallel testing capability - Ability to parallel test changes in Medical Policy or Rule changes online with test results and impact of changes documented and immediately available for State review and analysis
- Availability of resource allocation and utilization (man-hours) – both current and historical resource allocation/utilization must be maintained
- Maintain and support multiple project plan details with an auditing component to monitor on-going changes.

The web based project management application must serve as the access point to all program related documentation, including user and technical components, repositories of critical program information, and all related data models. The project management application must offer expanded communication protocols designed to support collaboration and document sharing activities.

5.15.2 System Support

The Contractor shall provide an automated Change Request Tracking System and a web-based project management application, which deliver the capabilities described above. The Contractor shall provide the State with a perpetual license for the use of these applications; ownership of the associated data files shall rest with the State. In addition, the State maintains a standalone tracking system to monitor system maintenance and modification change requests.

5.15.3 State Responsibilities

5.15.3.1 Manage the maintenance and modification process, insuring that processes for Change Request development, approval, and prioritization are followed.

5.15.3.2 Publish a governance structure to the Contractor to control the method and schedule for considering and executing system changes, including the determination of priorities at the discretion of the State.

5.15.3.3 Coordinate changes being done by multiple contractors, insuring that multi-system changes are appropriately planned and coordinated.

5.15.3.4 Monitor maintenance Change Requests, insuring that maintenance Change Requests are either completed according to the maintenance level matrix or are waived and documented in the Change Request tracking system.

5.15.3.5 Coordinate Change Request priorities according to the State's governance structure. Communicate priorities to State and Contractor staff.

5.15.3.6 When required, at the discretion of the State, coordinate the approval of test plans, including testing responsibilities, test data, and test results.

5.15.3.7 Insure that system, user, and operations documentation resulting from system changes is appropriate and receive according to required time frames.

5.15.3.8 Review and coordinate approval, for documented system workarounds deemed necessary until system changes are correctly coded and implemented into the Indiana*AIM* system.

5.15.3.9 Approve, in writing, changes to Contractor's system development methodology in place for processing system changes.

5.15.3.10 Review and approve Change Requests being released into production and communicate to State staff. Post-implementation review shall not be billed as a separate item, but shall be an automatic activity conducted by the Contractor using systems maintenance staff.

The State shall determine which Change Requests need a project manager assigned.

5.15.4 Contractor Responsibilities

Identification of System Changes and Participation in Change Control Process as specified by the State.

Level	Description	Definition	Standard
1	Emergency	System no longer functions.	Correct within one (1) business day.
2	Disabled – No Workaround	Business function or components of the business function do not work as required, and no workaround is available.	Correct within ten (10) business days.
3	Disabled - Workaround	Business function or components of the function do not work as required, but a workaround that is acceptable to the State is available until the problem is resolved.	Correct within twenty-five (25) business days.
4	Minor	Non-critical problems	Correct within forty (40) business days.
5	Minimal	Cosmetic	Correct within fifty (50) business days.

5.15.4.1 The Contractor shall comply with the requirements described in the Maintenance Level Table (above) for performance of maintenance activities. This matrix assigns a severity level, describes the type of maintenance problem to be corrected, and defines the time frame for problem resolution.

5.15.4.2 Document the discovery of system deficiencies (as reported by State, Contractor, or other contractor(s) within five (5) business days of discovery. Log deficiencies (brief description, date identified, person identifying problem and other attributes as required by the State) for review in the internal review process. Deficiencies that interrupt proper and timely claims payment must be reported to the State immediately and documented within twenty four (24) hours of discovery.

5.15.4.3 Prepare and assist State and other contractors in preparing draft Change Requests for review in the IR Process, detailing all required information. Upon IR approval, write final Change Requests and place the Change Request in the Change Request Library Management System.

5.15.4.4 Perform thorough and rigorous system testing of all changes using the ITF and other testing solutions, including regression testing, on Change Requests before they are promoted to the production environment. System test results must be available

for State review and submitted to, as necessary, the other contractors for evaluation.

5.15.4.5 Provide the necessary and appropriate staff to support the Initial Review Process and the Group and Global Priority Process.

5.15.4.6 For large-scale projects, submit requirements analysis and specifications to the State for approval. Adhere to the State-mandated system development and project management methodologies.

Maintenance and Modification Project Tracking and Reporting

5.15.4.7 Provide weekly reports of the complete Change Request inventory and Change Request hours for maintenance, modification, and other system activities to the State in the format and media approved by the State.

5.15.4.8 Provide on-line access to the State's Change Request Tracking System and associated files to State, Contractor, and other contractors.

5.15.4.9 Identify and maintain a current inventory of on-going periodic tasks (reports, data extracts, pricing file updates, etc.). Maintain a listing of on-going tasks within the State's Change Request Tracking System and complete tasks according to the established timeline for completion.

5.15.4.10 Work modification Change Requests in accordance with allocation targets for modification hours: All billable hours are worked against State prioritized and approved Change Requests.

Implementation of Maintenance and Modification System Changes

5.15.4.11 The Contractor must adhere to State-mandated system development and project management methodologies. The mandated methodologies must be utilized for all Change Request activities. The Contractor may request State approval for the use of a Contractor specific methodology.

5.15.4.12 For all Change Requests, walkthroughs must be conducted and State sign-off/approval must be received prior to implementation.

5.15.4.13 The Contractor shall offer walkthroughs as required by the State for all Change Requests and request State sign-off/approval prior to proceeding to the next stage in the

Information Systems Development Methodology. Walkthrough will include but are not limited to:

- Requirements
- Test results
- Documentation (code, assumptions, test results)

5.15.4.14 Contractor will utilize a State-approved project management methodology. The level of project management will be dependent on the size of the change. Project work plans and/or templates must be available to the State through the Contractor's web based project management application. Utilizing these project management tools will enhance the ability for the Contractor and the State to monitor the success of timely completion of changes and implementation. The goal should be to continuously improve and shorten completion time.

5.15.4.15 The Contractor shall code programs, create and modify screens and reports, create and modify interfaces and computer communications and perform all services necessary to control, accomplish and implement State-approved Change Requests.

5.15.4.16 Contractor must monitor and verify the successful implementation of the system changes documented in the Change Requests, as well as measure impact of system change within other operational areas. Change Request documentation must include at a minimum the following monitoring activities/statistics:

- Specific monitoring activities conducted
- Details concerning production processing
- Procedures for correcting any problems found
- Contingency plans if defects arise after implementation

5.15.4.17 The Contractor must draft, generate and submit to the State updates to applicable system, user, and operations documentation.

5.15.4.18 The Contractor will utilize the provisions regarding maintenance changes for deficiencies (rework) that are discovered after system changes are promoted into production.

5.15.4.19 The Contractor will review MMIS system components and suggest best-practice enhancements, accompanied by a written cost/benefit analysis.

5.15.4.20 The Contractor shall implement administrative and system changes that meet mandated State or Federal regulatory changes by the mandated implementation date or on the schedule agreed to by the State. The changes are billable to the Modification Pool unless mentioned as a Contractor requirement in the SOW.

5.15.4.21 The Contractor shall conduct mass updates (adjustments) of the applicable data sets as directed by the State. Mass updates resulting from system modifications are billable to the Modification Pool. Mass updates resulting from system deficiencies are not billable.

5.15.4.22 The Contractor shall submit an invoice documenting the Modification Pool resources utilized each month within ten (10) days of the end of the month.

Coordination Activities

5.15.4.23 The Contractor shall provide system integration expertise and appropriate staff to support 3rd-party implementations and modifications to the Medicaid Management Information System (MMIS).

5.15.4.24 The Contractor shall provide assistance to the State and State-designated contractors in the IR and priority processes.

5.15.4.25 The Contractor shall provide system documentation updates to the State and the other contractors for inclusion in manuals, bulletins, and newsletters utilizing the documented turnover procedures.

5.15.4.26 The Contractor shall interface with the State and the other contractors during the systems development and project management process, according to the provisions of the State-mandated methodologies.

5.15.4.27 The Contractor shall coordinate all system testing activities with the State and other contractors to ensure that system changes in Fiscal Agent operations or Indiana*AIM* do not adversely impact the operations of the State or other contractors.

5.15.4.28 The Contractor shall follow the state's governance structure as it may be modified from time to time regarding communications and work reporting requirements.

5.15.4.29 The State has the right to receive notification and participate in any requirements gathering, design, and walk-through.

5.15.4.30 Modification staff may not work on maintenance activities without the express written consent of the State.

5.15.4.31 The Contractor shall follow the State's change control process.

5.15.4.32 The Contractor shall obtain state approval prior to assigning a Project Manager to a Change Request.

5.16 CPAS and Medicaid Eligibility Quality Control (MEQC)

5.16.1 Overview and Business Objective

5.16.1.1 CPAS

The Contractor will be responsible for maintaining and supporting Indiana*AIM*'s CPAS component. CPAS is used to evaluate the accuracy of claims processing. The CPAS component of Indiana*AIM* supports the selection and review of a statistically valid sample of claims to determine whether the claims were processed properly, whether Federal and State regulations were applied appropriately, and whether the claim was paid or denied correctly. CPAS also supports focused reviews of claims or services to determine if the policies of the State are being applied accurately and consistently.

5.16.1.2 MEQC

The MEQC function is similar to the CPAS function in that the Core Contractor provides the State with automated sampling and reporting for reviews of member claims submissions. Information is then reviewed to determine errors.

5.16.1.3 Business Objective

The objectives for the CPAS function are to:

- Provide an overall assessment of the Core Contractor's claims processing.
- Provide a mechanism to measure the cost of deficiencies.
- Provide a mechanism to identify deficiencies in the claims processing operations.
- Provide a mechanism to evaluate recipients participating in the IHCP

5.16.2 System Support

Indiana*AIM*'s automated features supporting this function include the following:

- Generates monthly samples of both hard-copy and EMC-submitted IHCP claims for review by the State.
- Accepts electronic transfer and input of member sample criteria.
- Generates member data profile reports (online and paper).
- Generates claim history data sheets and claims payment analysis reports.
- Generates a report with automated MEQC sample selections of member information and submitted claims data.

5.16.3 State Responsibilities

5.16.3.1 Establish sample criteria for CPAS and MEQC and provide them to the Contractor. Review and approve or disapprove of changes in the CPAS and MEQC process as may be suggested by the Contractor.

5.16.3.2 Receive and review a monthly sample of both hard-copy and EMC-submitted Medicaid claims.

5.16.3.3 Review output reports and supporting claim documentation to identify any errors.

5.16.3.4 Advise the Contractor of detected errors.

5.16.3.5 Determine and monitor corrective action resulting from the findings.

5.16.3.6 Determine and interpret policy and make administrative decisions relating to the findings.

5.16.4 Contractor Responsibilities

5.16.4.1 Using State criteria, provide the State with selected claims samples for review. Suggest improvements to the CPAS and MEQC processes for approval by the State. Initiate improvements approved by the State.

5.16.4.2 Provide and maintain online inquiry capabilities, as required, to support State research of sampled claims.

5.16.4.3 Provide the State with legible supporting documentation for each sampled claim, including:

- A copy of the original claim and any attachments (hard-copy claims)
- A printout of original claim record (EMC claim) and any accompanying attachments
- Claim data sheets that contain recipient, provider reference, and claim information related to each sampled claim
- Member history profiles for each sampled claim

- Information shall be provided to the State within five business days of receipt of request in the format specified by the State.

5.16.4.4 Provide assistance to the State in researching discrepancies.

5.16.4.5 Supply to the State listings of sampled claims with the formats and contents to be specified by the State.

5.16.4.6 Respond to the State's discrepancy notices with a corrective action plan within ten business days of receipt of the notice from the State or within a time frame specified by the State.

5.16.4.7 Provide the State with the universe of claims from which samples were extracted, in a format to be determined by the State.

5.16.4.8 Make recommendations for process improvements where possible.

5.16.4.9 Accept electronic transfer and input of member sample criteria.

5.16.4.10 Provide the State with defined MEQC information for each sampled recipient for MEQC, including:

5.16.4.11 Member data profile reports (online and hard copy)

5.16.4.12 Claim history data sheets

5.16.4.13 Claim payment analysis reports

5.16.4.14 MEQC sampling information shall be submitted to the State within three business days of request in the format specified by the State.

5.16.4.15 Respond to State inquiries regarding claims samples within five business days of receipt of inquiry from the State.

5.17 Third-Party Liability Services

5.17.1 Overview and Business Objective

Ensuring that IHCP is the payor of last resort is the primary purpose of the Third-Party Liability (TPL) business function. Processes in this business function include researching, identifying, and invoicing other payment resources (such as private insurance, Medicare, etc.) for services provided to IHCP members.

TPL activity occurs both before and after payment of claims. If TPL resources are identified during claims processing, the claim will not pay unless the third-party resource has been billed and the claim is submitted with evidence of third-party payment or denial (referred to as cost-avoidance).

Postpayment recovery activities (referred to as pay-and-chase) center on invoicing third-party resources after payment is made on a claim. The TPL Unit is responsible for the collection of the TPL casualty dollars.

Processes that support the TPL business function are:

- Identify third-party resources available to IHCP eligible members.
- Avoid paying claims for members with active third-party coverage on file when no TPL payment is indicated.
- Maintain various files containing third-party resource information and update files through data matches with other government programs and private insurance carriers.
- Recover funds (also known as the retrobilling process) from providers or other payors when third-party resources are identified after payment, have been made in error, or are in accordance with pay-and-chase regulations.
- Establish TPL accounts receivable for third-party resources identified after payment.
- Recover funds due the State through casualty cases.
- Pay the premiums for private health insurance for a member when it is deemed cost-effective to do so in lieu of self-insuring full medical benefits coverage (HIPP).
- Support OBRA 93 requirements for the medical child support program.
- Effectively manage the program to consistently ensure cost-effectiveness.

5.17.1.1 Business Objective

The TPL business function is designed to meet three objectives:

- Ensure that the IHCP is the payor of last resort.
- Coordinate benefits with other payors.
- Recover funds due the IHCP

5.17.2 System Support

In support of TPL staff functions, the Indiana*AIM* system provides the following system functionality:

- Provides the ability to search for a member's TPL coverage information using the member's RID number or insurer's carrier number (assigned by the Contractor)
- Stores relevant Medicare coverage information, including Part A, Part B, or Part D designation and effective dates of coverage
- Stores multiple instances of third-party payors for each recipient, including policy number, carrier number, group number, employer information, policyholder's information, and coverage information (for example, types of services covered)
- Identifies paid claims that are eligible for postpayment recovery, generates claim facsimiles for submission to insurance carriers, and establishes TPL accounts receivable to track recoveries
- Provides the ability to add, update, and delete TPL resource information

- Provides the ability to create, track, and close TPL accounts receivable
- Supports billing in all media specified by the State (and available via the selected carrier)
- Provides the ability to track information for TPL-related correspondence (for example, send date, receipt date, sent-to address)
- Tracks information to support the Health Insurance Premium Payment (HIPP) program, including relevant recipient information, relevant carrier information, HIPP cost-effectiveness calculations, expenditure information, etc.
- Supports the establishment, tracking, and updating of casualty case liens
- Produces TPL reports
- Requires TPL resource information from State eligibility systems and transmits TPL resource information to State eligibility systems
- Performs external, cost-effective data matches with the following:
- State Police's motor vehicle accident report file
- Patient Compensation Board's malpractice suit file
- Department of Defense's Defense Eligibility and Enrollment Reporting System (DEERS)
- Performs an internal data match against claims paid with procedure codes associated with accident trauma cases

5.17.3 State Responsibilities

5.17.3.1 Review and approve implementation of Contractor-developed TPL policies and procedures.

5.17.3.2 Collect initial third-party resource information from all sources for all members via State eligibility systems.

5.17.3.3 Specify, with CMS approval, which coverage types are to be cost-avoided and which are to be paid and recovered, and change this specification when appropriate.

5.17.3.4 Approve changes to cost-avoidance and recovery policies.

5.17.3.5 Assist the Contractor in working out data exchange arrangements with insurance carriers and governmental agencies and in performing data exchanges.

5.17.4 Contractor Responsibilities

5.17.4.1 Develop policies and procedures for, and perform, TPL activities, including proper establishment of data for prepayment cost-avoidance and postpayment resource identification and recovery activities; all policies and procedures must adhere to applicable State and Federal guidelines.

5.17.4.2 Perform online updates to the TPL Carrier file and to TPL accounts receivable on a schedule approved by the State.

5.17.4.3 Research potential and update existing casualty cases.

5.17.4.4 Respond to TPL inquiries from State agencies.

5.17.4.5 Maintain accurate TPL information, including discovery, identification, verification, and gathering of additional information from all sources.

5.17.4.6 Perform follow-up and verification for changes to recipient TPL coverage identified through any TPL process or report or through the retrobilling process within 19 business days of receipt. Update the system within one (1) business day of confirming a TPL coverage update.

5.17.4.7 Perform regularly scheduled quality reviews of all TPL processes to ensure Indiana*AIM* and the associated manual processes are working to ensure the IHCP is the payor of last resort. Provide the State with a summary of each review. Make recommendations to the State to improve the overall TPL collection processes.

5.17.4.8 Identify, investigate, and report TPL resources that are either denied or below a State-established percentage of the billed amount.

5.17.4.9 Perform follow-up and verification of changes to member TPL coverage identified through all sources, including during claims processing, from county- or State-provided information, or through data matches. Record all verified changes using the TPL windows.

5.17.4.10 Enter TPL resource update information received via phone from caseworkers, the State, or private insurance carriers as it is received.

5.17.4.11 Enter updates to TPL resource information within 20 business days of receipt in the mailroom. Begin the process of verification when TPL resource information is received. The Contractor must use a tracking process to monitor this requirement. Update the system within two (2) business days of TPL verification.

5.17.4.12 Perform online and batch updates to the TPL resource file on a monthly basis to TPL data.

5.17.4.13 Maintain mappings between types of TPL coverage and covered services for cost-avoidance. Review the edit logic on an annual basis to ensure logic is efficient, effective, and in-line with industry standards. Submit recommended changes to the State for approval. Submit and annual report to the state summarizing the review process, findings and recommendations.

5.17.4.14 Initiate and track postpayment recovery actions from carriers for claims paid to providers that demonstrated a good-faith effort to collect from a known third-party resource but did not receive payment.

5.17.4.15 Process third-party financial recoveries.

5.17.4.16 Establish accounts receivable for TPL recoveries.

5.17.4.17 Follow established check-handling procedures for all TPL carrier checks reviewed, including logging, applying CCNs, copying, etc..

5.17.4.18 Deposit all checks received within 24 hours of receipt.

5.17.4.19 Log, track, and correctly disposition TPL recoveries received into Indiana*AIM* using the appropriate windows.

5.17.4.20 Perform research and resolve “non-dispositioned” checks for which the Contractor is responsible.

5.17.4.21 Utilize staff knowledgeable about TPL policies, procedures, and regulations (for example, OBRA-93) in the performance of the requirements set forth in this RFP.

5.17.4.22 Report to the State on a monthly basis a summary of the TPL recovery activities performed and collections received. Reporting of retrobilling information should include a

summary of the retrobilling, total collected, and outstanding accounts receivable balance.

5.17.4.23 Research and conduct analyses of collection trends over time. Include qualitative analyses, including overall Medicaid and insurance trends. Based on analysis make recommendations to the OMPP regarding future program/policy changes and enhancements.

5.17.4.24 Perform postpayment investigations of potential casualty/liability cases on a weekly basis and denied and low-dollar TPL claim recoveries on a monthly basis. Report on investigations and follow-up to recover monies due the State, including the establishment of liens on provider accounts according to policies or direction of the State.

5.17.4.25 Perform ongoing follow-up action on aged accounts receivable.

5.17.4.26 Identify eligible HIPP cases by performing a cost-effectiveness analysis of private insurance policies available to recipients. If payment of the policy is determined to be cost-effective, the Contractor shall ensure that premium payments are made. Cost-effective cases must be tracked monthly to confirm continued Eligibility, including continued fee-for-service eligibility. Cases must be reviewed annually to confirm continued cost-effectiveness.

5.17.4.27 The Contractor must maintain statistical data identifying numbers of HIPP members and dollars expended.

5.17.4.28 Annually, the Contractor must prepare a report that includes a statistical analysis of HIPP members served and estimated cost savings. The report should also include a recommendation concerning continued use or modification of the cost-effectiveness formula.

5.17.4.29 Produce TPL inquiry letters to attorneys, providers, carriers, and other parties as needed within five (5) business days from the date the need is identified.

5.17.4.30 Deliver all reports in accordance with the schedule and distribution list.

5.17.4.31 Develop, maintain, and submit to the State the TPL operations procedures manual. Updates to this manual must be distributed to the State within three business days following State approval.

5.17.4.32 Schedule and prepare agendas for TPL meetings with State staff. Meetings will be held at intervals specified by the State. Record and distribute meeting minutes for all TPL meetings with State staff within five business days.

5.17.4.33 Perform related litigation and administrative hearing activities (providing testimony, documentation, etc.), as needed.

5.17.4.34 Establish and pursue recovery of liens, authorized under IC 12-15-8, as necessary for casualty cases.

5.17.4.35 Research, resolve, and accurately respond to all written TPL inquiries, as directed by the State. Responses to inquiries from government officials are required within three business days of receipt. All other inquiries require a response within ten business days of receipt.

5.17.4.36 Provide toll-free (for Indiana and contiguous states) telephone lines dedicated to TPL purposes.

5.17.4.37 Maintain a sufficient number of telephone lines (for Indiana and the contiguous states) and personnel to staff the lines so that:

- Ninety-five percent of all calls are answered on or before the fourth ring.
- No more than five percent of incoming calls ring busy.
- Automated menus are efficient and are approved by the State. All menu selections except the most basic (English or Spanish?, Provider or Recipient?) have an option to select a live operator. From the time a user chooses a live operator, ninety-five percent of calls are answered by a live person within one minute. Hold time must not exceed one minute.

5.17.4.38 The average hold time must not exceed 30 seconds.

5.17.4.39 Call length is sufficient to ensure adequate information is imparted to the caller.

5.17.4.40 Staff TPL toll-free phone lines from 8 a.m. to 6 p.m., Indianapolis time, Monday through Friday (excluding State holidays).

5.17.4.41 Provide reports to monitor compliance with all TPL requirements.

5.17.4.42 Communicate with the attorneys, recipients, liable parties, etc., involved in a casualty case, as needed.

5.17.4.43 Perform post-payment investigations of potential and established casualty liability cases every six months or as needed. Review 90 percent of all case reviews within the calendar month in which the case review is scheduled. Review the remaining ten percent of the case reviews within the month following the originally scheduled review month. Report on all post-payment investigations monthly, and follow up on each to assure all payments and claims are properly disposition~~ed~~.

5.17.4.44 Provide legal support (in coordination with FSSA legal staff and the Attorney General's office, as necessary) for subrogation and to handle inquiries from attorneys representing recipients, etc.

5.17.4.45 Prepare and provide all necessary data to assist the State in completing the IHCP State Agency Third-Party Liability (TPL) Inventory form (CMS-64 report).

5.17.4.46 Provide birth expenditures information to the DFC offices within ten business days of request. The information shall be presented in a readable, user-friendly format.

5.17.4.47 Identify and pursue private insurance coverage for recipients when a non-custodial parent has been court-ordered to provide insurance when available. Identify employed non-custodial parents through data matches and generate letters to employers requiring them to enroll the child in their parent's insurance plan. Track compliance.

5.17.4.48 Update Indiana*AIM* to reflect TPL Medicare criteria and other TPL edit changes on an ongoing basis or as determined necessary by the State. Medicare coverage decisions must be reflected in Indiana*AIM* within 30 business days of Medicare's published announcement of the changes.

5.17.4.49 Resolve claims payment issues related to TPL.

5.17.4.50 Update Indiana*AIM* when Medicare coverage is verified for an IHCP member within one (1) business day of its verification.

5.17.4.51 Develop procedures for initiating adjustment requests when claim-specific TPL resources are received (for example, no TPL payment on original claim).

5.17.4.52 Review HCPCS updates for TPL edit coverage criteria.

5.17.4.53 Update TPL edits coverage criteria as needed.

5.17.4.54 Use CCN batch ranges to identify TPL check receipts for outstanding accounts receivable. TPL threshold calculations will only use receipts entered using these TPL-defined batch ranges.

5.17.4.55 Submit all claims for recovery if the TPL amount is greater than zero, regardless of the amount.

5.17.4.56 Provide TPL file information to other contractors as specified by the State.

5.17.4.57 Research and update the TPL resource file when TPL information is reported on a claim but there is no corresponding TPL resource on file for the recipient. The resource file must be updated within 20 business days following the ICN payment month.

5.18 Web Services

5.18.1 Overview and Business Objective

The primary function of the Web Services area is to provide a web site that is used to communicate with Indiana Medicaid providers. The Contractor must create and maintain an informational web site with a consistent site theme, which is capable of displaying information, documents and files. The site must also allow the authorized user to perform interactive transactions. Details of these requirements are outlined in the following sections.

Site Theme and Navigational Features
The site must meet the following requirements:

- Maintain a consistent theme throughout the site.
- Provide a Site Map.
- Provide multiple access points for main topics.
- Meet federal 508 accessibility standards.

General Information
The site must contain the following information:

- Frequently Asked Questions (FAQs)
- Provider workshop information
- Provider field consultant information
- Managed care information

- Links to other sites related to the Indiana Health Coverage Programs
- Links to sites offering free software to help access the downloadable documents on the site. These tools include Adobe Acrobat, an unzip utility, Internet Explorer, and Word Viewer.

Documents and Files
The site must provide access to the following documents and files:

- Bulletins (in .pdf format)
- Banners (in .pdf format)
- Provider Manuals (in .pdf format)
- Forms (in .pdf, Word and Excel format as appropriate)
- State Plan (in digitized format as appropriate)
- Fee Schedule (in delimited zipped file format for fast downloading)

Search Features
The site must provide a separate search for each of the following items:

- Site Search – full text site search
- Banner/Bulletin Search – searchable by keyword or document number
- Waiver Provider Search – multi-key search
- Fee Schedule Search – multi-key search
- Provider Directory Search – multi-key search
- Explanation of Benefit (EOB) description search

HIPAA-compliant transactions
The site must allow authorized users to perform the following HIPAA-compliant transactions:

- Interactive Eligibility Verification (270/271 – DDE compliant with an option for additional non-HIPAA-required information).
- Interactive Claims Inquiry (276/277 – DDE compliant with an option for additional non-HIPAA-required information).
- Interactive Claim Submission (837 – DDE compliant) to allow a provider to submit a claim for online adjudication, including HIPAA compliant responses.
- Batch claim file exchange - Accept a pre-formatted 837 - compliant batch claim file for processing.
- Batch provider remittance advice (835 - compliant) download.

DDE refers to the HIPAA definition for Direct Data Entry via the web.

Other Interactive Transactions
The following non-HIPAA-required functionality shall be provided:

- Provider web survey submission
- Provider check (payment) inquiry

- Birth expenditure inquiry
- Interactive provider enrollment (automated to the extent possible)
- E-mail submission by user initiated from a link on the website
- Direct mail services – bulk outgoing e-mail to registered users
- Provider training
- Project Workbook

5.18.1.1 Business Objective

The objective for the Indiana Health Coverage Programs web site is to develop and maintain a nationally recognized web site that offers Indiana Medicaid stakeholders a user-friendly environment with enhanced processing capability. The Contractor will leverage advancing technology to promote increased access to vital program information, offer claims adjudication and other transaction-based processing and expand educational focus by promoting digital learning programs.

5.18.2 System Support

The environment for the web site must be maintained in accordance to the following standards;

User IDs and Passwords

- Provide authenticated access for designated functionality.
- Provide a unique password and ID for each user of the functionality requiring authenticated access.
- Provide role-based security that allows each user to see only the data and applications for which the user is authorized.
- Provide access to authorized providers as well as other authorized individuals.

Security, Monitoring and Testing

- Provide data encryption through secure socket layer (SSL) technology to protect data.
- Provide dual firewalls to protect data on the web server as well as data on the application server.
- Provide an Intrusion Detection System (IDS) detect suspicious traffic.
- Provide web site monitoring to indicate when a web component has failed.
- Provide failover capability for essential web components so that a new component can be quickly installed when a component fails.
- Perform regular backups of the web servers and retain this data for one month.

- Provide a development web site (accessible to developers), a test web site (accessible to the State for pre-production approval purposes) and a production web site (available to the public).

Site Availability

Provide availability to the web site twenty (20) hours per day (6am through 2am the next day), seven (7) days per week, ninety-eight percent (98%) of the time. Unavailability of the site, caused by situations outside the Contractor's control or due to routine maintenance on the Indiana*AIM* application, is excluded from the downtime calculation. The State may grant a waiver of this requirement under emergency conditions. Routine system maintenance will be scheduled outside of the scheduled available processing hours.

Help Desk Operations

- Provide Web Help Desk support 8:00 am to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. local time, Monday through Friday (excluding state holidays).

Users may communicate with the Help Desk via phone, voicemail or e-mail.

5.18.3 State Responsibilities

5.18.3.1 Submit site improvement suggestions and requirements to Contractor.

5.18.3.2 Review and approve changes as needed.

5.18.3.3 Make Contractor aware of regulations (state, federal, and other) regarding the use of the Internet for transacting OMPP business.

5.18.3.4 Make the Contractor aware of evolving capabilities and standards associated with the State's common portal initiative

5.18.4 Contractor Responsibilities

5.18.4.1 Conform to regulations governing Internet transactions.

5.18.4.2 Proactively review and analyze the web site and recommend improvements to OMPP.

5.18.4.3 Implement changes on the IHCP site.

5.18.4.4 Maintain the IHCP site.

Coordination Activities

5.18.4.5 Coordinate with other State contractors to display pertinent information and effective integration. Providers should experience a seamless transition to and from content maintained by other State contractors.

5.18.4.6 Work with other state agencies to ensure Medicaid information is represented accurately and clearly on the IHCP site (currently www.IndianaMedicaid.com). Also ensure that the navigation between the IHCP and the state internal portal is easy to locate and understand.

5.18.4.7 Provide access to the Medicaid web site via an "IN.gov" URL.

5.18.4.8 Coordinate with appropriate State agencies to implement portal access and security changes as required to maintain consistency with evolving State standards and to migrate the site "look and feel" toward consistency with overall State standards as major enhancements are implemented.

5.18.4.9 The State shall retain ownership and rights of use for any URLs so registered and maintained at the conclusion of the contract. Additionally, the Contractor shall register and maintain registration for the domain names for the State web sites supported by the Contractor.

5.19 First Steps Early Intervention Program

All services, methods, standards, obligations, and other requirements from this RFP that apply to Indiana*AIM* and Medicaid Fiscal Agent operations apply to the Contractor's responsibilities for the First Steps program, if the State, at its sole option, agrees to contract for those services from the Contractor.

Certain Contract provisions are not directly applicable to First Steps. These will be itemized along with additional First Steps history and documentation in the Procurement Library.

5.19.1 First Steps Contractor Responsibilities

5.19.1.1 Maintain and operate the CRO, CCG, SPOE, and any future systems paid for under this contract.

5.19.1.2 Original Contract RFP references to Indiana*AIM* apply to the First Steps SPOE, CCG, CRO, and any future systems paid for under this contract.

5.19.1.3 Maintain First Steps systems (SPOE, CRO, Matrix Web-site)in accordance with the requirements for the IHCP. IHCP RFP system maintenance and enhancement requirements pertain to First Steps systems.

5.19.1.4 Accept and process daily data transfers from local SPOE data base. Send response files according to business rules established by the state.

5.19.1.5 Provide central SPOE system updates to distributed SPOE systems according to the schedule established by the state.

5.19.1.6 Send extracts of provider files to the SPOE systems.

5.19.1.7 Maintain the central database of all SPOE data (CCG).

5.19.1.8 Provide a duplicate copy of the consolidated central SPOE (CCG) database referenced in FSC - 7 to State and State contractors on a twice monthly schedule as specified by the state.

5.19.1.9 Maintain the SPOE system to allow service plan entry and transmit authorizations for service to Indiana AIM through the HIPAA 278 standard transaction.

5.19.1.10 Maintain the Matrix Website. All RFP references for IHCP or Medicaid web site apply to the Matrix Website for First Steps.

5.19.1.11 Display all enrolled First Steps Providers on the Matrix Website.

5.19.1.12 Maintain a central directory of state and federal resources for families and children with disabilities on the Matrix Website as directed by the state.

5.19.1.13 Perform fund recovery subrogation services. Prepare claims for identified health plans and Medicaid as directed by the state.

5.19.1.14 Develop a method, in conjunction with the state, to update TPL information from the First Steps SPOE and communicate the information to AIM and ICES.

5.19.1.15 Apply TPL recovery dollars to the appropriate fund as directed by the state.

5.19.1.16 Identify First Steps Claims on recovery attempts to other carriers.

5.19.1.17 Create a process to prevent attempts to recover dollars from other carriers when a client waiver has been completed requesting that insurance not be billed.

5.19.1.18 Develop a process to recover funds from CSHCS.

5.19.1.19 Resubmit claims to Medicaid when Medicaid eligibility match for a First Steps member is retro-actively identified.

5.19.1.20 Submit claims with appropriate units according to Correct Coding Initiatives to Medicaid.

5.19.1.21 When CPT and HCPCS codes are updated, review updated codes for correct coding on Medicaid claim submissions for First Steps.

5.19.1.22 Submit void / replacement claims to other carriers and Medicaid when a void / replacement claim is submitted to First Steps.

5.19.1.23 Provide access through Web-interChange for the state First Steps staff to have the same functionality for research and resolution of First Steps Medicaid claims as IHCP providers.

5.19.1.24 Accurately calculate monthly co-payment for members based upon federal and state laws and regulations.

5.19.1.25 Reconcile a co-payment amount for services that are reimbursed by other carriers including Medicaid as mandated by federal and state laws.

5.19.1.26 Mail a monthly consolidated co-payment statement to members according to the established state schedule.

5.19.1.27 Establish and maintain lock box for FS member payments.

5.19.1.28 Mail an adjusted co-payment statement to members for any months where TPL has been collected after the initial co-payment statement.

5.19.1.29 Support local SPOE inquiries and training needs.

5.19.1.30 Track SPOE issues and report issues to state contacts within two business days of issue identification.

5.19.1.31 Prepare TANF Federal Reporting. Ensure that reporting is accurate.

5.19.1.32 Provide data extracts of paid claims to the State and/or State Contractor on a twice monthly schedule as specified by the state.

5.19.1.33 Provide a monthly report to the state of denied claims for Medicaid recoupment with a first level group by denial reason, second level group by SPOE, and sorted by child.

5.19.1.34 Accept and process recipient match extract to update vendor match file from the state's data warehouse as mandated by the state.

5.19.1.35 Comply with Federal Education Rights and Privacy Act in performance of all First Steps related vendor activities.

5.19.1.36 Maintain the First Steps Billing Manual and SPOE User Manual with appropriate updates within ten (10) business days of a change to the processes documented in the manual or within ten (10) business days of receipt of a mandated change by the state.

5.19.1.37 Update appropriate operating procedure manuals as mandated by the state.

5.19.1.38 Display PA status information for First Steps approved services on the Web interChange.

5.19.1.39 The Individual Family Service Plan serves as the Prior Authorization for First Steps services.

5.19.1.40 Do not pay providers for services rendered without a valid license.

5.19.1.41 Process 100% of First Steps provider enrollments and updates within 10 business days of receipt.

5.19.1.42 Recredential providers yearly. Provide a 60 day and 30 day reminder to providers that they are due for recredentialling. Process 100% of recredentialling documents within 10 business days of receipt.

5.19.1.43 Provide to the state mandated contacts, on a monthly basis, a list of newly enrolled providers.

5.19.1.44 Provide technical assistance to First Steps Contractor as necessary to support SUR and Policy.

5.19.1.45 Support and update the First steps SUR files.

5.19.1.46 Identify and communicate leads on potential fraud and abuse cases to the state mandated contact.

5.19.1.47 Provide matching services to identify First Steps members who are also Medicaid members. Historically 46% of the First Steps population has Medicaid coverage. The Medicaid match must be a minimum of 46%.

5.19.1.48 Where eligibility interfaces with ICES are mentioned in the RFP of the Original Contract. The requirement is applicable with the SPOE system as well.

5.19.1.49 Process all First Steps provider claims within 15 business days of receipt.

5.19.1.50 Provide claims extracts for utilization review to the state mandated contacts.

5.19.1.51 Suspend claims submitted beyond the filing limit as directed by the state.

5.19.1.52 Provide monthly case count reports to FSSA Finance on members multiple eligibility for First Steps, Medicaid, Children's Special Health Care (CSHCS) and TANF by Referral, Intake, and IFSP status as necessary.

5.19.1.53 Provide monthly members reports to FSSA Finance at detail and summary level by Federal Poverty Level with both Co-payment and TPL recovery related information.

5.19.1.54 Provide necessary financial management services including reporting to FSSA Finance specific to First Steps on provider claims/payments, TPL recovery and Cost Participation payments.

5.20 Pharmacy Claims Adjudication (PCA)

The Contractor will be responsible for pharmacy claims adjudication. For pharmacy-related processing the Contractor provides pharmacy claims processing and related functions, e.g., point-of-sale (POS) edits; prospective drug utilization review (Pro-DUR) alerts; third party liability (TPL) services; and claim extracts for auditing and drug rebate administration. The Contractor is responsible for recipient eligibility maintenance and the

eligibility verification system (EVS), provider services, management and administrative reporting (MAR), financial management, and the technical platform to perform prior authorization services.

5.20.1 Contractor Responsibilities.

5.20.1.1 Process all pharmacy claims in a HIPAA-compliant, NCPDP 5.1 and 1.1 formats

5.20.1.2 Accept and correctly process compound pharmacy claims via POS.

5.20.1.3 Provide short-text responses on all POS submitted claims where an edit supports a response.

5.20.1.4 Ensure all NCPDP 5.1 format Third Party Liability cost avoidance codes are available for use by the providers and are functioning and compliant with NCPDP standards.

5.20.1.5 Ensure dispensing fees are applied to claims in full compliance with applicable dispensing fee policy.

5.20.1.6 Obtain, from a nationally recognized source ("vendor"), a drug file to be used for purposes including, but not necessarily limited to, the correct, proper, and accurate adjudication of pharmacy claims. Obtain from the same vendor and apply, on at least a weekly basis, updates to the drug file. OMPP reserves the right to approve or disapprove of the Contractor's selection of drug file vendor, but the Contractor remains liable for the accuracy and appropriateness of claims payment amounts that are determined based on information on the drug file. The drug file shall be maintained by the Contractor such that it correctly depicts the preferred drug list ("PDL") status of PDL-applicable drugs. In addition to standard information typically included on the drug file, the file shall show in an intuitive and simple manner, for each line item NDC, UPC, HRI, or other code (1.) whether the code is for a drug or a non-drug item; (2.) whether the code is for a Medicaid covered or Medicaid non-covered service; (3.) if for a drug, whether it is brand or generic; (4.) if for a drug, whether it is legend or non-legend ("OTC'). The Contractor shall coordinate efforts with other contractors, as necessary, in identifying and performing all updates to the drug file necessitated by PDL or other program changes, doing so in a time frame that ensures processing of drug claims fully in compliance with provider bulletins and program policies.

5.20.1.7 Suspend high dollar compound claims to appropriate PCA suspense region or location as directed by OMPP for review and disposition by the PBM Contractor(s).

5.20.1.8 Suspend POS claims as OMPP policy dictates, beyond those claims meeting the criteria of PCA-9. Adjudicate suspended POS claims in accordance with requirements outlined in the FA RFP regarding claims adjudication for paper attachments.

5.20.1.9 Provide a PCA system that fully supports the pharmacy program by ensuring that all edits and audits functioning for pharmacy claims processing are available no later than July 1, 2005.

5.20.1.10 Conduct accurate data entry and processing of paper and batch pharmacy claims in accordance with the requirements outlined in the FA RFP.

5.20.1.11 Develop, maintain and provide systems support for both the current spend-down methodology and the proposed spend-down methodology into the PCA system. The spend-down functionality will be available on April 1, 2005 and operational on September 1, 2005.

5.20.1.12 Utilize Indiana*AIM* eligibility information on a real-time basis to process pharmacy claims.

5.20.1.13 Provide claims status to providers in accordance with applicable HIPAA and NCPDP standards.

5.20.1.14 Provide the Pharmacy Auditing Contractor with files of paid pharmacy claims at least monthly in a format that is agreed upon by both EDS and the Pharmacy Auditing Contractor. Files provided by EDS will include supporting recipient and provider information.

5.20.1.15 Re-price pharmacy claims as requested by the Pharmacy Audit Contractor and return the re-priced file to the pharmacy claims auditor within 10 business days of receiving that file from the Pharmacy Audit Contractor.

5.20.1.16 Provide telephone helpdesk to respond to claims processing questions, and those policy questions for which answers can be retrieved from existing written, web, or other reference sources.

5.20.1.17 Provide a pharmacy claims manager and a pharmacy tech that are dedicated to the PCA project prior to implementation of the second phase. After implementation, provide a dedicated pharmacy tech to facilitate communications with OMPP, the PBM Contractor, other contractors, pharmacists and associations, and to support translation of pharmacy criteria into specific table values. Also, continue to provide pharmacy claims management expertise though such resource is not required to be solely dedicated to PCA or this contract.

5.20.1.18 Make available in BusinessObjects all OMPP specified Indiana*AIM* pharmacy data elements, including but not limited to elements in the drug file, the claim file and the PA file.

5.20.1.19 The PCA must use and support the most current required NCPDP billing standard. Any change to the NCPDP billing standard will be evaluated and changes made to the PCA system upon the approval of OMPP.

5.20.1.20 Convert all applicable historical claims and PA data from March 23, 2003 forward that were processed in the NCPDP 5.1 standard and submitted by the PBM Contractor(s) within agreed upon specifications within sixty business days of receipt to accurately reflect the claims in history as they were processed.

5.20.1.21 Establish and maintain a mechanism to share necessary claims information with the PBM Contractor(s), as needed for PBM Contractor(s) to perform assigned duties.

5.20.1.22 Allow connectivity and access by the PBM Contractor(s) to Indiana*AIM* windows relevant to the performance of functions of the PBM contract, including but not limited to rebates, RetroDUR, and PA. EDS is authorized to charge the PBM Contractor(s) a reasonable monthly fee for connectivity and software licenses per seat. EDS time and materials to fulfill data extracts requests by the PBM Contractor(s) will be applied to the Modification Pool hours.

5.20.1.23 Develop and maintain a PA window that provides the functionality to systematically populate PA elements from denied claims.

5.20.1.24 Maintain an interface with appropriate contactor(s) to receive and load Over-The-Counter (OTC) and Legend State Maximum Allowable Cost (SMAC) updates.

5.20.1.25 Maintain Medicaid pharmacy communications for providers, such as manuals, on the EDS Medicaid WEB site.

5.20.1.26 Provide for POS to be available for claim editing and adjudication for pharmacy claims at a minimum of twenty three (23) hours per day, seven d business days per week, ninety-eight (98) percent at the time, not including scheduled down time for OMPP approved maintenance and upgrades.

5.20.1.27 Provide advance, written, OMPP approved notification to the provider community, various vendors and intermediaries when changes to the NCPDP standards are implemented to the program.

5.20.1.28 Develop and provide reports as required by the State. Modify the Monthly Status Report to reflect pharmacy information as requested by the State.

5.20.1.29 Provide an adjustment reason code for adjustments related to the Pharmacy Auditing Contractor.

5.20.1.30 Provide a drug rebate adjustment reason code (or codes).

5.20.1.31 Work with other pharmacy-claim related contractors to define appropriate CCN batch ranges, and establish the agreed-upon batch ranges to support the disposition of checks received by other contractors in support of other business functions.

5.20.1.32 Provide the capability to determine benefit plans based on member related information. Support benefit plan driven edit processing, audit, pricing, co-payment, coverage and prior authorization requirements based on table configuration. Establish/enforce a hierarchy of benefit plan processing for members who have multiple concurrent benefit plans.

6 Proposal Evaluation Criteria

6.1 Proposal Evaluation Procedure

The State has selected a group of personnel to act as a proposal evaluation team. Subgroups of this team, consisting of one or more team members, will be responsible for evaluating proposals with regard to compliance with RFP requirements. All evaluation personnel will use the evaluation criteria stated in Section 6.2. The Commissioner of IDOA or her designee will, in the exercise of her sole discretion, determine which proposals offer the best means of servicing the interests of the State. The exercise of this

discretion will be final. The state may secure the services of an outside expert individual/entity to assist in the evaluation of proposals in any areas the state wishes additional review of proposals.

The procedure for evaluating the proposals against the evaluation criteria will be as follows:

6.1.1 Mandatory Requirements

Each proposal will be evaluated for adherence to certain requirements on a pass/fail basis before proposals are further evaluated. Proposals that are incomplete or otherwise do not conform to proposal submission requirements may be eliminated from consideration at the sole option of the State. The State reserves the right to allow a Respondent to correct minor deviations from requirements at the sole option of the State.

6.1.2 Evaluation Categories

Each proposal will be evaluated on the basis of the categories included in Section 6.2. A point score has been established for each category.

6.1.3 Evaluation Formula

Proposals will be evaluated based upon the criteria detailed in Section 6.2. A 100 point scale will be used and points will be awarded to the sections of the proposal according to section 6.2.

6.1.4 Contract Negotiation

Based on the results of this evaluation, the qualifying proposal determined to be the most advantageous to the State, taking into account all of the evaluation factors, may be selected by IDOA and FSSA for further action, such as contract negotiations. If, however, IDOA and FSSA decide that no proposal is sufficiently advantageous to the State, the State may take whatever further action is deemed necessary to fulfill its needs. If, for any reason, a proposal is selected and it is not possible to consummate a contract with the Respondent, IDOA may begin contract preparation with the next qualified Respondent or determine that no such alternate proposal exists.

6.2 Evaluation Criteria

Proposals will be evaluated based upon the proven ability of the Respondent to satisfy the requirements of the RFP in a cost-effective manner. Each of the evaluation criteria categories is described below with a brief explanation of the basis for evaluation in that category. The points associated with each category are indicated following the category name (total maximum points = 100). If any one or more of the listed criteria on which the responses to this RFP will be evaluated are found to be inconsistent or incompatible with applicable federal laws, regulations or policies, the specific criterion or criteria will be disregarded and the

responses will be evaluated and scored without taking into account such criterion or criteria.

Summary of Evaluation Criteria:

Criteria	Points
1. Adherence to Mandatory Requirements	Pass/Fail
2. Management Assessment/Quality (Business and Technical Proposal)	35
3. Cost (Cost Proposal)	20
4. Indiana Economic Impact	15
5. Buy Indiana	10
6. Minority (10) and Women Business (10) Subcontractor Commitment	20
Total	**100**

All proposals will be evaluated using the following approach.

6.2.1 Evaluate Mandatory Requirements

In this step proposals will be evaluated only against Criteria 1 to ensure that they adhere to Mandatory Requirements. Any proposals not meeting the Mandatory Requirements may be disqualified **under the provisions of Sections 3.2** and 6.1.1. Proposals will be evaluated to ensure that the proper number of copies were received by the due date and that all tabs as described in Section 3.1 are included in the proposal, and are complete.

6.2.2 Short List

The proposals that meet the Mandatory Requirements will then be scored based on Criteria 2 and 3 ONLY. This scoring will have a maximum possible score of 55 points. All proposals will be ranked on the basis of their combined scores for Criteria 2 and 3 ONLY. This ranking will be used to create a "short list". Any proposal not making the "short list" will not be considered for any further evaluation.

Step 6.2.2 may include one or more rounds of proposal discussions focused on cost and other proposal elements.

6.2.3 Final Evaluation of Short List Proposals

The short-listed proposals will then be evaluated based on all the entire evaluation criteria outlined in the table above.

If the State conducts additional rounds of discussions and a BAFO round which lead to changes in either the technical or cost proposal for the short listed Respondents, their scores will be recomputed.

The section below describes the different evaluation criteria.

6.2.3.1 Management Assessment/Quality (35 points)

Management Assessment/Quality will be evaluated based upon the quality of the responses in the Business Proposal and in the Technical Proposal. The sections that will be evaluated for the Business Proposal are outlined in Section 3.1, Tab 2, 2a-2m, and for the Technical Proposal in Section 3.1, Tab 3, 3a-3h.

The state may require the Respondents to provide references for specified staff or for corporate references. The state will supply the Respondent with the prescribed format of reference checks and from whom the reference check shall be supplied and the Respondent shall secure the reference checks and have it submitted directly to the state from the individual or firm supplying the reference.

The proposal with the highest score will be awarded 35 points. Other proposals will be awarded points based proportionately on the score of the proposal receiving the highest score.

6.2.3.2 Price (20 points)

The proposal with the lowest price bid will be awarded 20 points. Other proposals will be awarded points based proportionately on the price of the bid relative to the price of the lowest bid.

6.2.3.3 Indiana Economic Impact (15 points)

See Section 3.6.2 for additional information.

The total number of full time equivalent (FTE – please see Appendix A for a definition of FTE's) Indiana resident employees for the Respondent's proposal (prime contractor and subcontractors) will be used to evaluate the Respondent's Indiana Economic Impact. Points will be awarded based on a graduated scale. The Respondent with the most Indiana FTEs will be awarded 15 points. Points will then be awarded to the remaining Respondents proportionately.

6.2.3.4 Buy Indiana Initiative – 10 points

Respondents qualifying as an Indiana Company as defined in Section 3.6.3 will receive 10 points in this category.

6.2.3.5 Minority & Women's Business Subcontractor Commitment - (10 points each for a total of 20 points).

The following formula will be used to determine points to be awarded:

The commitment factor for each proposal will be calculated by multiplying the commitment percentage by one hundred. The RFP score ration will be determined by dividing the maximum allowable points by the highest commitment factor. The proposal with the highest commitment factor will be given the maximum allowable points. The points awarded to the other proposals will be calculated by multiplying the score ratio by the proposed commitment factor.

Commitment percentage * 100 = commitment factor
Maximum allowable points/highest commitment factor = score ratio
Commitment factor * score ratio = points awarded

Discretion of the Secretary of the Family and Social Service Administration

The Secretary of FSSA or his designee will, in the exercise of his sole discretion, determine which proposal(s) offer the best means of servicing the interests of the State. The exercise of this discretion will be final.

Appendices

Appendix A: Glossary of Terms

590 Program—A State program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health that provides payment for medical services rendered outside of the institution.

Ad Hoc Request—A request to provide non-production reports.

Adjudicate—To determine whether all program requirements have been met and whether the claim can be paid, denied or suspended or the encounter data would be paid or denied.

Adjudicated Claim—A claim that has reached final disposition such that it can either been paid or denied or determined if it would be paid or denied.

Adjustment—A transaction that changes any payment information on a previously paid claim.

APD—Advanced Planning Document

ARCH—Aid to Residents in County Homes. A State-funded program that provides payment for medical services to certain residents of county nursing homes.

AVR—The automated voice-response system used by providers to obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization for IHCP participants.

AWP—Average wholesale price; used for drug pricing.

BCDS.—Bureau of Child Development Services.

BENDEX—Beneficiary Data Exchange. A file containing data from the Centers for Medicare and Medicaid Services regarding persons receiving Medicaid benefits from the Social Security Administration.

Bill—Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

Buy-In—A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.

CCF—Claim correction form. A paper form generated by Indiana*AIM* and sent to the provider that submitted a claim that failed initial screening. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.

CCG—Central Claim Gateway, the First Steps CRO Claims System

CCN—Cash control number. A financial control number assigned to uniquely identify transactions.

CFR—Code of Federal Regulations. The Federal regulations that implement and define federal Medicaid law rules and regulations.

Change Request—An initiative from the Contractor, the State, or State-designated contractors to change Contractor Supported systems.

Claim—A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State using standardized claim forms HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.

CLIA—The Clinical Laboratory Improvement Amendments. A federally-mandated set of certification criteria and data collection monitoring system designed to ensure the proper certification of clinical laboratories

CMMI—Capability Maturity Model Integration. An Information Technology (IT) system development methodology developed and promoted by Carnegie Mellon University to measure and certifies the methods and controls used by a company or agency in the development of IT systems.

CMS—Centers for Medicare and Medicaid Services. Effective August 2001, this is the new name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. The division of the US Department of Health and Human Services responsible for federal oversight of the Medicaid program in each state. It was formerly known as the Health Care Financing Administration (HCFA).

CMS-1500—CMS-approved standardized claim form used to bill professional medical services.

CMS MSIS Report—The CMS MSIS Report, formerly the HCFA-2082 Report, is the basic source of state-reported eligibility and claims data on the Medicaid population, their characteristics, utilization, and payments. Through FY 1998, the HCFA-2082 was an annual State submitted report designed to collect aggregate statistical data on Medicaid eligibles, recipients, services, and expenditures during each federal fiscal year. States summarized and reported the data processed through their own Medicaid claims processing and payment systems unless they opted to participate in The Medicaid Statistical Information System (MSIS) where the 2082 Report was produced by CMS. State-by-State national summary tables were developed based on the 2082 Reports. As a result of legislation enacted by The Balanced Budget Act of 1997, States, beginning in FY 1999, are required to submit all of their eligibility and claims data on a quarterly basis through MSIS. The State requirement for completing the HCFA-2082 Report has been eliminated.

Cognos Reports—An Enterprise reporting tool that give you access to a list of self-serve report types, is adaptable to any data source, and operates from a single metadata layer

COTS—Commercial-Off-The-Shelf

Contract Amendment—Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract

Contractor—Any successful Respondent selected as a result of the procurement process to deliver the products or services requested by this RFP.

County Office—County offices of the Division of Family Resources. Offices are responsible for determining eligibility for the IHCP using the Indiana Client Eligibility System (ICES).

Covered Service—Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for services provided to eligible IHCP members.

CPAS—Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.

CPT—Current Procedural Terminology codes used for billing of health care services.

CRO—Central Reimbursement Office for First Steps

CRFs/DD—Community Residential Facilities for the Developmentally Disabled.

CSHCS—Children's Special Health Care Services. A State-funded program administered by the Indiana State Department of Health that provides assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.

Customer—Individuals or entities that receive services or interact with the contractor in supporting the IHCP, including State staff, members, and IHCP Medicaid providers, including managed care PMPs, managed care organizations, and waiver providers.

Denied Claim—A claim for which no payment is made to the provider because the claim is for non-covered services, is for an ineligible provider or recipient, is a duplicate of another similar or identical transaction, or does not otherwise meet State standards for payment.

Designee—A duly authorized representative of a person holding a superior position.

DHHS— The United States Department of Health and Human Services. Responsible for the administration of Medicaid at the federal level via the CMS.

Disaster Recovery and Back-Up Plan—A plan to ensure continued claims processing through adequate alternative facilities, equipment, back-up files, documentation and procedures in the event that the primary processing site is lost to the contractor.

DME—Durable medical equipment. Examples include wheelchairs, hospital beds, and other non-disposable, medically-necessary equipment.

DRG—Diagnosis-related grouping. Used as a basis for reimbursement of inpatient hospital services.

Drug Rebate—Program authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in which legend drug manufacturers or labelers enter into an agreement with the Secretary, DHHS, to provide financial rebates to states based on dollar amount of their drugs reimbursed by the Medicaid program.

DSH—Disproportionate share hospital. A category defined by the State identifying hospitals that serve disproportionately higher numbers of indigent patients.

DSS—Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.

DTS—Division of Technology Services.

DUR—Drug Utilization Review. A federally-mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.

EAC—Estimated acquisition cost; used in drug pricing.

ECC—Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS or EMC.

ECS—Electronic claims submittal. Claims submitted in electronic format rather than paper. See ECC or EMC.

EDP—Electronic data processing.

EFT—Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.

EI—Early Intervention.

Eligibility File—A file that maintains pertinent data for each Medicaid eligible recipient.

Eligibility Verification—Refers to the process of validating whether an individual is determined to be eligible for health care coverage through the Medicaid program and/or a

provider is qualified to provide services to the Medicaid population. Eligibility for the recipient and provider is determined by the State.

EMC—Electronic media claims. Claims submitted in electronic format rather than paper. See ECC or ECS.

Encounter Transactions—Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, billed amounts, and rendering/billing providers.

EIX—Early Intervention Explorer, the Claims System User Interface.

EOB—Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.

EOP—Explanation of payment. Description of the reimbursement activity on the provider's remittance advice.

EPSDT—Early and Periodic Screening, Diagnosis, and Treatment, known as HealthWatch in Indiana. EPSDT is a federally-required component of the Medicaid program for IHCP-eligible members younger than 21 years old, offering preventive health care services such as screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.

EVS—Eligibility Verification System. System used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice response system.

FEIN—Federal employer identification number. A number assigned to businesses by the federal government.

FERPA—Family Education Rights Protection Act, 20 U.S.C 1232g. 34 CFR Part 99

FFP—Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.

FIPS—Federal information processing standards.

Fiscal Agent—Refers to the Contractor operating the Indiana*AIM*. A contractor who provides MMIS operations and services specifically defined in Section 5, Scope of Work, for FSSA OMPP.

Fiscal Year - Indiana—July 1 through June 30.

Fiscal Year - Federal—October 1 through September 30.

FSSA—Family and Social Services Administration. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. The Office of Medicaid Policy and Planning (OMPP) is part of the FSSA, and is designated as the single State agency responsible for administering the Medicaid program.

FTE—Full Time Equivalent. The State defines FTE as a measurement of an employee's productivity on a specific project or contract. An FTE of 1 would mean that there is one worker fully engaged on a project. If there are two employees each spending 1/2 of their working time on a project that would also equal 1 FTE.

HCBS Waiver—Home- and Community-Based Services waiver. A Federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS waivers can include services such as adult day care, respite care, homemaker services, training in activities of daily living skills, and services not normally covered by the Medicaid state plan. HCBS services are typically provided to eligible members to allow them to live in the community and avoid being placed in an institution.

HCI—Hospital Care for the Indigent program. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.

HCPCS—Health Care Procedure Coding System. A uniform health care procedural coding system approved for use by the CMS. HCPCS includes all subsequent editions and revisions thereof.

HealthWatch—Indiana's preventive care program for IHCP members younger than 21 years old, also known as EPSDT.

HIC #—Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security Number and an alphabetic suffix that denotes different types of benefits.

HIO—Health insuring organization.

HMO—Health maintenance organization. Organization that delivers and manages health services under risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs.

Hoosier Healthwise—IHCP's managed care program. Hoosier Healthwise has two delivery systems: Primary Care Case Management (PCCM), and risk-based managed care (RBMC).

HRI—Health-related items.

IAC—The Indiana Administrative Code.

IC—The Indiana Code.

ICD-9-CM—International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.

ICES—Indiana Client Eligibility System. The system used by caseworkers in the county offices of the Division of Family and Children to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF). ICES also serves as the intermediary for files from the Social Security Administration.

ICF/MR—Intermediate Care Facility for the Mentally Retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.

ICN—Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.

IDOA—Indiana Department of Administration. Conducts State financial operations, including purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.

IMD—Institutions for mental disease.

Implementation—The successful implementation of Fiscal Agent and Medicaid Management Information System programming and operation services as specified in the contract resulting from this RFP.

Indiana*AIM*—Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).

Installation—The delivery and physical setup of products or services requested in this RFP.

ISDM—INFORMATION SYSTEMS DEVELOPMENT METHODOLOGY. A formal process to organize, execute, and document the development of information systems projects, approved by the State to manage the work and produce artifacts appropriate to the platforms being used for development.

ISMA—Indiana State Medical Association.

ITF—Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.

ITOC—Information Technology Oversight Commission. The Indiana agency overseeing agency compliance with all State data processing statutes, policies, and procedures.

JCL—Job control language.

LAN—Local area network.

LOC—Level of care. Medical LOC review determinations rendered by the OMPP staff for purposes of determining nursing home reimbursement.

Lock-In—Restriction of a member to particular providers, as determined necessary by the State.

LTC—Long-term care. Facilities that supply long-term residential care to members.

MAC—Maximum allowable charge for drugs.

MARS—Management and Administrative Reporting Subsystem. A federally-mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.

MCO—Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also HMO and Prepaid Health Plan.

MEQC—Medicaid eligibility quality control.

Medicaid Fiscal Agent—Contractor that provides the full range of services supporting the business functions included in the core and non-core services packages.

Medical Policy Contractor—Contractor responsible for all Medical Policy, PA, and SUR functions.

MMIS—Medicaid Management Information Systems. Indiana's current MMIS is Indiana*AIM*. The system certified by the US Centers for Medicare and Medicaid Services and operated by the Fiscal Agent to provide mechanized claims processing for Medicaid as defined in the Code of Federal Regulations and ancillary information technology services defined by the State.

MRN—Medicare remittance notice. An explanation of Medicare benefits (formerly known EOMB). The MRN details the payment or denial of claims submitted by providers for services provided to members.

NCPDP—National Council for Prescription Drug Programs.

NDC—National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.

NPIN—National provider identification number.

OMNI Device—Point-of-sale device used by providers to scan member ID cards to determine eligibility.

OMPP—Office of Medicaid Policy and Planning.

Other Governmental Body—An agency, a board, a branch, a bureau, a commission, a council, a department, an institution, an office, or another establishment of any of the following:

(1) The judicial branch.
(2) The legislative branch.
(3) A political subdivision (includes towns, cities, local governments, etc.)
(4) A state educational institution.

PA—Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.

PASRR—Pre-Admission Screening and Resident Review. A set of federally-required long-term care resident screening and evaluation services, payable by the Medicaid program, that was authorized by the Omnibus Budget and Reconciliation Act of 1987.

PCCM—Primary care case management. One of two delivery systems within the Hoosier Healthwise Managed Care program. Providers in PCCM are reimbursed on a fee-for-service basis. Members are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the member and providing all primary care and authorizing specialty care for the member 24 hours a day, seven days a week.

PMBOK™—THE PROJECT MANAGEMENT BODY OF KNOWLEDGE – A library of project management skills, tools and standards used by the Project Management Institute to measure and certify Project Management Professionals.

PMP—Primary medical provider. A physician who approves and manages care for physician and hospital services for Medicaid recipients in managed care assigned to the PMP's care.

POS—Place of service or point of service, depending on the context.

PPO—Preferred provider organization. An arrangement between a provider network and a health insurance carrier or self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care.

PRO—Peer review organization.

Pro-DUR—Prospective Drug Utilization Review. The federally-mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all Federal prospective DUR requirements and all DUR requirements.

Products—Tangible goods or manufactured items as specified in this RFP.

Proposal—An offer as defined in IC 5-22-2-17.

PSU—Provider Services Unit - A unit within the Fiscal Agent's operation to meet requirements of provider enrollment, maintenance and servicing to meet the requirements of this RFP.

QDWI—Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose income is less than 200 percent of the Federal poverty level. IHCP benefits cover payment of the Medicare Part A premium only.

QMB—Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals who are entitled to Medicare Part A and whose incomes are less than 100 percent of the Federal poverty level and assets less than twice the SSI asset limit. IHCP benefits include payment of Medicare premiums, coinsurance, and deductibles only.

RA—Remittance advice. A summary of payments produced by Indiana*AIM* along with provider reimbursement. RAs are sent to providers along with checks or EFT records.

RBMC—Risk-based managed care. One of two delivery systems within the Hoosier Healthwise managed care program. In RBMC, a managed care organizations is reimbursed on a per member basis per month to manage the member's health care.

RBRVS—Resource-based relative value scale. A reimbursement methodology used to calculate payment for physician, dental, and other practitioners.

Recipient—A person who has been determined to be eligible for assistance in accordance with the state plan(s) under Title XIV and Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, and/or Title IV of the immigration and Nationality Act.

Respondent—An offeror as defined in IC 5-22-2-18. The State will not consider a proposal responsive if two or more offerors submit a joint or combined proposal. One entity or individual must be clearly identified as the Respondent who will be ultimately responsible for performance of the contract.

RFP—Request for Proposal – The document that describes to prospective contractors the requirements of the fiscal agent, Indiana*AIM*, terms and conditions and technical information.

RID NUMBER—Recipient Identification Number assigned by Indiana Client Eligibility System (ICES) when an applicant requests public assistance.

RUG— (resource utilization groups) Classification of patients regarding nursing staff and therapy case mix

SDX—State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.

Services—Work to be performed as specified in this RFP.

SLIMB—Specified low-income Medicare beneficiary. A Federal category of Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the Federal poverty level and assets less than twice the SSI asset level. IHCP benefits include payment of the Medicare Part B premium only.

SPR—System performance review.

SSA—Social Security Administration of the federal government.

SSI—Supplementary Security Income. A Federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.

State—The State of Indiana, specifically the Indiana Department of Administration (IDOA), acting on behalf of the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the designated authorized person or persons delegated and acting in official capacity to conduct this procurement or to manage the Contract resulting from this procurement.

State Agency—As defined in IC 4-13-1, "state agency" means an authority, board, branch, commission, committee, department, division, or other instrumentality of the executive, including the administrative, department of state government.

Subcontractor—Any person or firm undertaking part of the work under the terms of a contract, by virtue of an agreement with the prime contractor, who, prior to such undertaking, receives in writing, the consent and approval of the State.

SUR—Surveillance and Utilization Review - Refers to SUR system functions and activities mandated by the CMS necessary to maintain complete and continuous compliance with the CMS regulatory requirements for SUR, including the following requirements: SPR requirements for SUR include statistical analysis; exception processing; provider and recipient profiling; retrospective detection of claims processing edit/audit failures/errors; retrospective detection of payments and/or utilization inconsistent with State or Federal program policies and/or medical necessity standards; retrospective detection of fraud and abuse by providers or recipients; sophisticated data and claim sampling, analysis, and reporting; general access and processing features; and general reporting and output.

Systems Analyst/Engineer—Responsible for performing the following types of activities:

- Detailed system and/program design
- System and /program development
- Maintenance and modification analysis and /resolution
- User needs analysis
- User training support
- Developing personal IHCP knowledge

System Point of Entry (SPOE)—System Point of Entry, the local entities responsible for eligibility determination and enrollment of First Steps children.

TANF—Temporary Assistance for Needy Families. Non-entitlement successor program to Aid to Families with Dependent Children (AFDC).

TANF MOE—Temporary Assistance to Needy Families Maintenance of Effort.

TPL—Third-party liability. A client's medical payment resources, other than the IHCP available for paying medical claims. These resources generally consist of public and private insurance carriers.

UB-92—Standard claim form used to bill hospital inpatient and outpatient, nursing facility, ICF/MR, and hospice services.

UCC—Usual and customary charge.

UPC—Universal product code. Codes contained on the First Data Bank tape update and applied to products such as drugs and other pharmaceutical products.

UPIN—Universal provider identification number.

VFC—Vaccine for Children program.